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THE STUDY OF STRUCTURE IN ITS RELATION TO PRACTICAL MEDICINE.

The Oration on Medicine delivered before
the Medical Society of New Jersey
at its 140th Annual Meeting.

By Joseph Tomlinson, M. D.,
Bridgeton, N. J.

Mr. President, Members of the Medical Society of New Jersey and Guests:

In coming before you as the orator on medicine of this venerable society, I do it with a feeling of deep appreciation of the honor bestowed upon me and with an equally strong sense of my inability to do justice to the task imposed.

Our opinions, professional and otherwise, are influenced very greatly by the point of view, and the ideas presented in this paper are advanced from my position as a humble worker in the ranks of the profession. From this standpoint they seem to involve some of the most practical and important questions of the time.

Whatever there may be of criticism of existing conditions in the field of medicine, is only such criticism as one would offer a friend, prompted by the most loyal and kindly feelings and with the sole object of stimulating, in some slight degree, a greater zeal in the service of the profession, here and now represented by this Society, assembled for the one hundred and fortieth time in its history.

Permit me to invite your attention to some considerations of the study of structure and function in its relation to practical

medicine. The relative importance of anatomy and physiology in comparison with the other branches of the science of medicine is a factor variously estimated. These subjects are regarded by the average undergraduate in medicine very much as are Latin and Greek by most students in the classical course of our colleges, as dry and devoid of interest, and worthy only of being forgotten as soon as the examinations have been passed. The student's ardor to accomplish great deeds in practical therapeutics or to gain laurels in the field of surgery blinds him, for the time being, to the importance of the essential and fundamental elements of practical medicine. Unfortunately this attitude never changes in a very large percentage of physicians, and their whole professional life is passed in a constantly increasing ignorance of the structure and functions of the human body.

As the devotee of literature finds that a knowledge of Latin and Greek unfolds to him some of the greatest sources of thought and inspiration in history, art and letters, so a very small minority of the medical profession fully realize that a knowledge of structure and function is the essential prerequisite to definite diagnosis and rational treatment.

This minority consists of teachers of the branches referred to, of specialists, whose work requires special knowledge of special organs, of surgeons, who must of necessity, have more than an ordinary knowledge of anatomy and of a very few from the great class of general practitioners who, under most adverse conditions, endeavor to do their work conscientiously and scientifically.

It is to these, the general practitioners of medicine, that the writer wishes to make a

plea for a better and more general understanding of structure and function, believing, as he does, that this is the very essence of scientific work; and knowing, as we all do, that the standing of the profession in general is chiefly determined by those of its members who, in their travels through the highways and by-ways of this broad land, enter the homes and reach the hearts of the people. It behooves us, therefore, to see that the confidence thus reposed is fully merited and that we are living up to the highest standard of professional work.

The present status of the allied sciences of structure and function is the resultant of studies and investigations extending over a long period of years and conducted from many and diverse viewpoints. By early writers and teachers they were considered almost exclusively as preparatory to the study of medicine, and as such were denominated proems or institutes of medicine. As the knowledge of normal structure was supplemented by a knowledge of structure in disease and macroscopic investigations were amplified by microscopic discoveries, a new light was shed upon them.

They came to be looked upon as a means of discovering the nature and cause of disease quite as much as preliminaries to the study of the other branches of medicine. There is, perhaps, no better exponent of the men who helped to establish their study as a means to this end than the late Professor Virchow. The most of his eventful and splendid life was directed to the propagation of his theory of the anatomical principle in disease.

While success has not crowned all of the many efforts based upon his theory, the failures have only served to stimulate an analogous series of investigations founded upon physiological or functional rather than upon anatomical or structural observations.

The study of comparative anatomy also bears a most important relation to medical science, involving, as it does, the theory of evolution and the variation of species. Not only does it interest the physician as an abstract science in his effort to solve the problem of the origin of the genus homo, but in a more definite and practical sense it bears upon the mysterious and unsolved question of heredity. The inheritance of character and of characteristics, physical, mental and moral, variations from the normal type, and the inheritance of disease itself, are all subjects of most vital importance, and all may perhaps be elucidated by more complete biological investigations.

Such, in brief, is the position of the sciences of anatomy and physiology in their relation to practical medicine. They are not only descriptive of normal structure and normal function, but are also a requisite for the full comprehension of the nature of disease, the detection of its presence, and the interpretation of its symptoms. They are to be viewed by us not as a foundation upon which a huge superstructure is to be erected, ponderous and ornate, but rather as a workman's tool, ever ready and at hand.

From the standpoint of the physician, what is the bearing on his daily work of this vast and varied knowledge? It becomes his duty, indeed it is a very necessity, to have at hand such facts and principles in anatomy, physiology and pathology, as are essential for correct diagnosis and rational treatment. His standing as a scientific man will depend absolutely upon the degree to which he adheres to this principle and accomplishes this end. His attitude toward these branches will determine, in a professional way, the trend of his thoughts and the character of his thinking.

It is very natural upon the basis of an indefinite generalization to institute an elaborate treatment, which assuages the medical conscience and lulls the patient into a false sense of security by the fact that so much is being done. But such procedures belong to the age of empiricism. The present age demands that no pains be spared to trace the relation of antecedent and consequent, of cause and effect.

How can the ordinary physician be brought to a higher standard of knowledge in these branches? It would be presumptuous to attempt a complete solution of this most important problem. The suggestions here made are, however, as far as they go, the natural outgrowth of practical experiences with the general practitioner on the one hand and the specialist on the other.

They may be formulated as follows:

First. By a truer conception of the duties and status of the general practitioner. The general practice of medicine should stand for something definite with specific limitations and requirements. It seems, in fact, in view of recent developments, quite necessary to define the terms "medicine" and "practice of medicine."

The writer has found two definitions, one by a man of science, the other by a man of the law, which are in harmony and complete.

The first definition was given by Huxley in 1881 and was as follows: "Taken in a broad sense 'medicine' not merely denotes a

kind of knowledge, but it comprehends the various applications of that knowledge to the alleviation of the sufferings, the repair of the injuries, and the conservation of the health of living beings. In fact, the practical aspect of medicine so far dominates every other that the 'healing art' is one of its most widely received synonyms."

The other definition was recently given by Judge Joseph I. Green, of the New York City Court. It is this: "The practice of medicine is the exercise or performance of any act, by or through the use of anything or matter, or by things done, given or applied, whether with or without the use of drugs or medicine, and whether with or without fee therefor, by a person holding himself or herself out as able to cure disease, with a view to relieve, heal, or cure and having for its object the prevention, healing, cure, or alleviation of disease."

These definitions given twenty-five years apart, one by an Englishman, the other by an American; one by a physician and scientist, the other by a lawyer and a judge, are identical in spirit.

Concerning medicine as a calling, the words of President Faunce, of Brown University, in a recent address before the Rhode Island Medical Society, are well worth recalling. He said: "In two respects the medical profession deserves the grateful recognition and regard of all other callings in modern life. It has always insisted that the practice of medicine is a profession and not a trade. Trade is occupation for livelihood; profession is occupation for service of the world. Trade is occupation for joy in the result; profession is occupation for joy in the process. Trade is occupation where anybody may enter; profession is occupation where only those who are prepared may enter. Trade is occupation taken up temporarily, until something better offers; profession is occupation with which one is identified for life. Trade makes one the rival of every other trader; profession makes one the coöperator with all his colleagues. Trade knows only the ethics of success; profession is bound by lasting ties of sacred honor."

In the final analysis the qualities demanded in the physician are twofold. They are ethical and scientific. They consist of ideals and ideas. Ideals alone will not make a competent physician. He must also possess adequate knowledge, judgment and studiousness. Diagnostic ability comprehends the latter requisites and diagnosis is the watchword of the scientific physician.

To enter the field of general practice as a makeshift, to consider it a catch-all for the unfortunates and incompetents of the profession, to expect here a lower standard of ability or less thorough preparation than in specialism, to think that diagnostic errors can be atoned for by therapeutic zeal, to seize it as an opportunity for finesse rather than fitness, to count success by dollars accumulated rather than by work performed, is to stultify oneself, degrade and commercialize the profession and grossly deceive the public.

Lack of diagnostic ability is not, however, invariably due to lack of knowledge of structure and function, in health and disease. Failure in diagnosis, on the part of the general practitioner, is very often due to faulty methods of examination. Especially is this true in the management of uterine cases. A specialist will insist upon the most favorable conditions before giving a diagnosis. Why should not the physician do the same? Proper position, proper light, the removal of obstructing clothing, and it may be anesthesia, are insisted upon by the specialist. It is the duty of the physician, both as regards himself and his patient, to do the same. In regard to the man who neglects entirely physical examination of such cases as cancer of the uterus and allows them to reach the specialist too late, perhaps, for operation, there can be no possible excuse. Duty in diagnosis is not, however, completely performed by a naming of the disease.

Every disease must be considered with reference to the individual. Age, sex, habit, as of plethora or the reverse, individual idiosyncrasy, drug susceptibility, temperament, coexisting disease, hereditary influences, all have a very practical bearing upon the proper estimate of a case both as regards diagnosis and treatment. As has been said by a recent writer, "it is quite as necessary to know what kind of a man the disease has got as to know what kind of a disease the man has got." The prevailing carelessness in this phase of diagnosis is evinced by the widespread habit of prescribing ready made tablets of complex formulæ.

No attempt is made to study the individualities of the case, but "Rheumatic, No. 4," "Antidyspeptic, No. 2," "Bronchitis, No. 3," and many other conveniently numbered and ready labeled products of commercialized pharmacy, are bought at reduced rates, in fifteen thousand lots, and scattered to unsuspecting patients like corn to chickens.

Every offer of such preparations by the manufacturing druggist is a tacit imputation against the diagnostic ability and therapeutic acumen of the physician, and the indiscriminate use of such combinations is a practical acknowledgment of such imputation.

After *Collier's Weekly* and *The Ladies' Home Journal* have finished their crusades against the patent medicine evil, we would respectfully commend to them some missionary work in this field, a field, it seems, quite ripe for the harvest.

Second. The physician should constantly endeavor to refresh his memory in anatomy, physiology and pathology, and should seize every opportunity to add to his knowledge in these branches. The text books on these topics, so often relegated to the dusty shelves, should be in the working library of every physician for frequent review and ready reference. Autopsies are most instructive; and while generally difficult to obtain in private practice are one of the many advantages offered those living in the vicinity of hospitals. The more general establishment of clinical societies and the more frequent discussion of subjects chosen from this field of thought in our county and other societies would stimulate wider interest.

The organization of the profession which has been effected and which is being constantly more perfectly completed is one of the most potent factors existing to-day. From the American Medical Association, from the State Societies, and from the County Societies, influences are emanating which are felt in legislative halls, which are promoting good fellowship, and which are making us stronger in the financial aspect of our work as physicians.

But a factor, more potent than all such influences, is the opportunity here afforded for cultivating and strengthening the scientific spirit. Not until every physician in every county, in every State of the United States, is made to feel that membership in the County Society is indispensable to his scientific growth, will the process of organization be complete.

Perhaps, however, there is no more instructive or impressive method for the physician to study pathology, than by witnessing surgical operations. This he should do at every opportunity. It is very doubtful if anything did so much to bring the medical and surgical worlds to a consensus of opinion on the subject of appendicitis as actual demonstrations on the operating

table. No physician, after witnessing a few such operations in the various stages and phases of that disease, could seriously advocate any medical treatment.

And nothing could so impress upon a physician the seriousness of a chronic middle ear discharge, as a mastoid operation or an operation for infective sinus-thrombosis. Such demonstrations are worth more to him, in a practical way, than whole volumes of text books or hours of lectures.

Third. Some changes in the methods of medical teaching are evidently required.

The representative medical colleges have for several years past been endeavoring to raise the standard of medical education. This has been accomplished, chiefly, by a higher standard of entrance requirements and by a lengthening of the prescribed course of study. The educators have said: "Give us a better equipped man and we will make the physician." Either consciously or unconsciously, intentionally or unintentionally, there has been a growing tendency toward specialism in medical teaching. Now, in a protest against this attitude, the plea is going up from various quarters of the profession, to give us the physician first and make the specialist afterward. Much of the so-called "standard raising" has been a mere exploitation of knowledge on the part of the teacher. The head of each department attempts to make the students under him specialists in that branch.

In an address before the Minnesota State Medical Society, Dr. F. F. Wesbrook, professor of pathology and bacteriology, University of Minnesota, made the following summary as to present methods and needs in medical teaching:

"It is probable that the teaching of to-day is too diversified and that the attempt is made to cover too much ground. At best, the student can only be taught certain general principles and how to observe. It is, therefore, best to illustrate the methods of observation by the thorough study of a few disease processes rather than to attempt to cover the whole field of medicine. If he be properly taught how to approach his cases in a systematic way and to utilize every method of observation, the student's only difficulty will be to weigh the evidence which his eyes, ears, hands, microscope or chemic tests afford him. If he is able to diagnose accurately the commoner disease processes and the changes which have been produced in the various tissues and organs of the body; if he knows the general principles of therapy and is taught to advise his

patient and to protect others with whom he may be brought in contact, he can easily adapt the same methods to the study of other processes and other diseases when the necessity for it arises. Such a general plan of teaching will eliminate the dangers of too great specialization, whether along laboratory or clinical lines, and will promote the use of logical methods of deduction and neutralize the present tendency to 'cock-sureness,' with the possible oversight of important associated or causative conditions."

Such an opinion carries with it special weight, coming, as it does, from a well-known teacher. It is to the teacher we must look for a readjustment of methods in medical education. His appreciation of his duties, his conscientious desire to perform these duties, his willingness to let the profession of teaching be the *end* rather than a *means to further private ends*, will form a safe basis for the final solution of this question.

In an address to the students of the faculty of medicine in University College, London, Mr. Thomas H. Huxley defined the duties of a teacher. He said: "What the student needs in a professor is a man who shall stand between himself and the great diversity of knowledge and present to him that which he should assimilate and which is capable of being assimilated by his mind."

If this statement, made by one of the most profound thinkers the world has ever produced, and one of the foremost educators of his time, was true in England, more than a quarter of a century ago, it is doubly true in the United States to-day.

The deduction to be drawn is, that more stress should be laid, in medical teaching, upon those subjects which will give the student the means of scientific thinking, no matter into what specialty he may eventually gravitate; and less time should be devoted to educational refinements which have no especial relation to scientific medical training.

By a practical and thorough application of this very simple principle on the part of medical teachers, the specialist would be a better man; the physician would be a better man; and the patient would be in an infinitely better position; for he would receive more intelligent treatment on the part of the physician and would be more promptly referred to the specialist as occasion required.

Such are some of the means which have suggested themselves for raising the stand-

ard of work in the rank and file of the medical profession. It depends upon an underlying principle even more than upon abstract knowledge. Knowledge is infinite and in spite of the most zealous efforts there will still be a vista of the unknown beyond.

His attitude as a seeker after knowledge will determine the character of the man. It is the habit of mind quite as much as the retentive memory, which differentiates between a scientific and an unscientific physician.

Though his work has to do with physical problems, yet there is, from an ethical standpoint, a close analogy between the physician and the artist. The work of the artist is not a mere reproduction of form and color. It is the broad and comprehensive grasp of great truths intelligently expressed by the methods of his art. His field is the aesthetic and the spiritual and his object is always the same whether it be in painting, in poetry, in sculpture, or in the drama.

So the work of an intelligent physician involves the personal application of broad principles. Without the ability to do this he goes through the form of his work, without getting at the substance of it. His efforts bear the same relation to what they should be that a doggerel rhyme bears to a poem of Tennyson. And as the artist should ever aim to impress on his work the lofty ideals of beauty, truth, and virtue, so it becomes our duty, unceasingly to strive toward a more perfect understanding of the structure and functions of that wonderful piece of mechanism—the human body—which is committed to our care, as devotees of the healing art, in sacred trust.

Shall we fulfill this trust intelligently and conscientiously? Shall we do it in the spirit of the men whose lives were spent in dissecting rooms and laboratories that we, of the present, might have so rich an inheritance of knowledge? Or shall it be done in that spirit of empiricism, which has been the blight of the past? Or of commercialism, which is the curse of the present?

The answer to these questions rests in part with each and every one of us.

A general federal inspection of the Nation's Milk Supply is strongly urged. The whole system of milk production and distribution is declared to be wrong, and the attempt to secure a pure product by means of pasteurization or sterilization is claimed to be rank nonsense so long as there is no government control of the methods. As regards State food commissions, inspectors are usually mere politicians who will inspect anything in any way a farmer or dairymen asks them to.—*American Medicine*.

THE ORATION ON SURGERY—DELIVERED AT THE 140th ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

By

Thomas W. Harvey, M. D.,

Orange, N. J.

It is impossible in a short address to cover the whole field of surgical progress; so quickly is the field enlarging; so kaleidoscopic are the changes; so much are the surgeons learning from the rapid development of physiology and pathology; so much are they adding to the therapeutic lore of the profession. I will, therefore, only attempt to touch upon those subjects that seem to me most interesting, trusting that the presentation may seem worthy.

Surely this is the age of surgery. To one who well remembers the introduction of the teachings of the great Lister into medical circles in New York, the changes that have taken place in surgical practice appear like the products of a magician's wand.

How well I remember seeing the lamented Detmold demonstrate in the amphitheater in the old Twenty-third street building, the technique of the new antiseptic surgery. Even to the student the incongruity between the principles of the new teaching and their application in that grewsome old "Pit" were painfully evident. In the same arena I recall seeing T. Gaillard Thomas exhibit a woman who had sustained a hysterectomy as a "rara avis"; and he commented on the wisdom of his London colleague, who had supplied his patient with a letter, warning any venturesome Yankee from introducing the uterine sound. A wise warning, as the sound was an important means of gynecological diagnosis in the seventies. In the same place, officiating as prosecutor sat the embryo surgeon who was to be the first to remove a diseased appendix in the city of New York. Well says the Latin poet, "*Forsan et haec olim meminisse juvabit.*"

For twenty years it has been the surgeon's day. Every year he has added new fields, devised new operations, improved his technique, until with ready scalped and conservative suture he has invaded the very citadel of life itself. Has opened the pericardium, sutured the heart and come off scot-free.

Not only has the surgeon invaded many new fields, but he has taken over whole organs and entire groups of diseases, and in-

stead of waiting around as of old until the internist, tired of guessing and experimenting, calls him in as a last resort, he is loudly demanding a chance at the very beginning of the disease, confidently urging the value of the exploratory incision as a proper diagnostic measure.

To illustrate I have only to instance the gall bladder operations and the gastro-enterostomies which are now made to relieve chronic dyspeptic symptoms, which for centuries have been the reproach of medicine and a measureless source of wealth to the empiric. Again in the surgery of the urinary bladder we have a great example of progressive surgery. One of the real functions of the healing art is to render old age comfortable, and to guard the individual from such accidents as are due to the mechanical results of senile changes. The relief which surgery is giving prostatics in delivering them from the dangers of catheter life has been a great improvement, and the improved technique that has reduced the mortality to a negligible quantity in a particularly susceptible group of patients is a notable evidence of surgical advance.

Without entering into the refinements of the dispute between the adherents of the supra-pubic and the perineal routes, it is very clear that with one or the other of the two methods many old men are being relieved from the dangers and discomforts of catheter life, and valuable lives have been prolonged. This is a great gain for surgery, because, hitherto it has had little to offer to the evening of life.

In many fields the surgeon is only held back at present from even greater successes, by the lack of knowledge for which he must wait further progress in physiology and pathology. With greater knowledge of the physiology of the stomach and pancreas, and the true significance of early departures from the norm., will come earlier operations and the cure of pathological conditions which are now unrecognized, and which precede the invasion of incurable malignancy.

Dr. Maurice Richardson in an address before the American Medical Association raises the query, "Who shall do surgery?" and details the long and arduous special training a medical man should add to the usual course in order that he may become a qualified surgeon. He emphasizes the value of a long apprenticeship as assistant to some skilled operator, which apprenticeship should come as the culmination of a thorough preparatory course. Dr. Richardson puts this none too emphatically. Before one

assumes the responsibility incident to surgical practice, there should have been full opportunity for seeing the best work done. There is no royal road. Yet it is necessary to-day for many to do surgery and to be ready to meet its responsibilities.

The multiplication of small hospitals all over the land, where emergency cases continually are brought that require immediate operation, throws the responsibility of being ready to perform the most important operations upon the local staff. And there is greater need of skilled surgeons than formerly because we have learned to interfere successfully in so many emergencies, which formerly were fatal because of the inadequacy of surgery, and which now recover by reason of the greatly improved surgery of to-day.

Erichson, in his "Science and Art of Surgery," edition of 1873, enumerates the operations necessary to rescue the patient from immediate and inevitable death. The list is as follows: Tying a bleeding artery, opening the wind-pipe in laryngeal obstruction, relieving an over distended bladder, dividing the stricture in strangulated hernia. To this should be added, trephining for depressed fracture.

Emergency surgery to-day includes a long list of abdominal sections, for perforation of hollow viscera, for internal hemorrhage and for penetrating wounds. Operations which call for the most perfect technique and the cleverest manipulation, and which can rarely wait for the coming of the metropolitan consultant.

Moreover, surgery has taken over so many diseases that formerly belonged to the internist, that the general practitioner has changed his management of such diseases *pari passu* with the changing fashion, and, just as formerly when treating gall stone colic, he shifted from chloroform to sweet oil, so when surgery claimed that the proper method of treating this group of diseases was with the knife, it was easy and natural for him to change his treatment and become a surgeon whenever such cases fell to his lot.

Surgery is claiming the lion's share of all diseased conditions situated below the diaphragm. It was not so long ago the custom to publish a resumé and an analysis of your cases of laparotomy when they reached the century mark, and now it is hardly good form to report on results from less than a thousand operations of the same kind, or at most of the same organ.

This change of treatment from medical

to surgical has gone to such an extent that one has to do surgery if one wishes to keep up with the advances of the times, or indeed keep in practice. Tending toward the same effect the medical colleges are turning out their graduates imbued with the idea that surgery is the only treatment for most diseases, and educating them as general surgeons rather than general practitioners. Moreover, more students, to-day, have the opportunity, as hospital internes, to learn proper technique and become familiar with operative work. Your modern surgeon is a marvel of technique. Time was when inerrant accuracy of anatomical knowledge, and ability to work quickly and certainly under the most adverse circumstances were the qualifications necessary to a surgeon. Then the surgeon was born, not made.

Many of us remember him, dressed in an immaculate frock coat with rose in button-hole, as he turned up his sleeves and amputated a thigh while an attendant, watch in hand, counted the seconds.

To-day the surgeon's success depends largely upon faithfulness to the minute details of his art. It is being learned again, however, how important are the minutes as factors in the recovery from an operation, and it is undoubtedly true that a patient, whose operation is over in thirty minutes, can take more chances of a faulty technique, than can one who spends an hour and a half on the table.

Moreover, we are learning to discard more and more of the unessential in our work. The crux of success being that everything that enters into or approaches the wound shall be absolutely sterile.

With all this great advance in surgery, and despite the great increase of practitioners of the art, I think there is a steady and distinct advance in conservatism. Conservative surgery does not mean withholding the use of the knife until the last moment, nor does it mean niggardly incisions or partial operations in the presence of diseases that are not limited in their nature and development. To remove a mammary cancer and to leave a lot of infected glands is not conservative surgery. Nor is operating on the third day of an appendicitis instead of the first an indication of conservatism.

The essentials of conservatism in surgery are:

Early operation.

Wide excision in malignant disease.

Preservation of organs in suppurative and benign disease.

Protection of the patient during operation.

Myomectomy instead of hysterectomy is often conservative, and frequently an early myomectomy is particularly so.

This is illustrated by a case from whom I removed an ovarian cyst on account of acute strangulation by a twisted pedicle. It was an emergency operation in the presence of a beginning peritonitis; and although several small fibroids, like cherries, were noticed in the uterus, it was deemed inadvisable to remove them on account of the danger of infection. Within one year the rapid growth of the fibroids and the resulting pressure symptoms necessitated a pan-hysterectomy, with the result of sterilizing my patient.

There are many times when incision and drainage will cure the disease and heal the patient better than the excision of an organ.

The clinician who has seen a suppurative otitis media recover with complete restoration of function to the ear; who has tapped a circumscribed empyaema and removed a pint of pus, and has seen the patient recover without permanent injury to the lung; who has incised, removed the stone, and drained an obstructive pyelitis and has had complete recovery of function with normal urine; has a right to the opinion that in so far as surgery fails to cure suppurative inflammation in an organ by incision and drainage, and has to resort to wide excision, by just so much our art falls short of what it should be able to do, viz.: to cure local diseases by local treatment without resort to curative measures which will add further mutilation to that already caused by the disease.

It is a common experience to find at a second laparotomy the absence of all indications of a previous suppurative inflammation which has been opened and drained. It only remains for us to discover what the conditions are that are necessary for such complete recoveries, to be able to treat our pelvic inflammations more rationally. I am certain that with the perfection of our technique, it will come to pass that a woman with a pelvic inflammation, within or without the pelvic organs, will be cured without having had any of her organs removed.

I think that the tendencies of to-day in gall bladder disease, to do a cystectomy instead of a cystotomy is a progression backwards, unless there is a distinct limitation of excision to gall bladders so diseased that they may not ever recover their function.

We have not the knowledge at present that justifies us in holding the gall bladder to be an effete and useless organ, such as we have come to regard the appendix vermi-

formis. Moreover, removal of the gall bladder does not go beyond the disease; not only are the bile passages affected beyond the limit of the exsection, but they are liable to become infected again and give rise to new crops of gall stones; and cases have been reported where they have dilated so as to form a new reservoir to take the place of the excised gall bladder.

The surgery of the bile passages and the near-by organs is the center of the greatest surgical interest to-day. The problems of the lower abdomen are so nearly solved that they have lost their greatest attraction, while those of the upper part have been exploited just enough to keep the operator on the *qui vive* for new developments in the pathological mysteries of the new country. Here are the newest things, and here we are learning a lot of new pathology and forgetting a lot of the old.

In no other region has the surgeon added more to the healing art since he learned the technique of successful abdominal section. One feels this when he has made a choledochotomy on a patient whose misery and pain from the pressure of stones in her common duct has extended over many years, and no one has promised anything but palliation. I recall such a patient who, despite the fact that she had never had jaundice, and whose history had been one of long continued and frequently recurrent attacks of pain, still had five stones as large as hickory nuts in her common duct besides others in the gall bladder. Their removal was followed by complete recovery.

The chief difficulties for the abdominal surgeon lie in the direction of diagnosis. Most valuable aid is now available from the clinical laboratory, which has become as necessary to the surgeon as to the physician.

Chemical, physical and microscopical examinations of the excreta, of the blood and of the tissues all may be used to elucidate a given problem. It has to be remembered, however, that useful as are these methods, they form only a part of the diagnostic process. Their findings have always to be interpreted in the light of the clinical history.

The laboratory not only assists in making the differential diagnosis between operable and inoperable cases, between conditions requiring quick generous surgery, and those requiring rest and mechanical measures, but often indicates the favorable opportunity for operation and enables us to make a more accurate prognosis.

The presence or absence of albumen in the urine determines the kind of anaesthetic

to be used, and as diabetes is often the cause of gangrenous ulcers and is also a dangerous factor in surgical operations, when sugar is found in the urine we are guided in our choice of the character and location of the procedure to be adopted.

Indican, when found in any appreciable quantity in the urine, indicates intestinal fermentation. The amount present in the urine is a fair index of the digestion of the proteid substances in the food. While it is found in many gastric and intestinal diseases, it is present in much increased quantities in carcinoma of the stomach owing to the absence of free hydrochloric acid, and the test is useful in the differential diagnosis from ulcer; and again with symptoms of intestinal obstruction, increased excretion of indican is more likely to occur when the obstruction is in the small intestine than when it is in the colon.

Cryoscopy.—The determination of the freezing point of a given specimen of urine or blood is useful in determining the adequacy of the renal function and the respective condition of each kidney.

When occasion arises for removing a diseased kidney, the other kidney is pretty certain to be healthy if cryoscopy shows a normal freezing point and inferentially the sufficiency of the renal excretion. With the other tests, this method is said to be fairly reliable when urine from both kidneys may not be collected separately.

Glycerine has been found in the urine in certain diseases of the pancreas, and its presence there, indicative as it is of deficient digestion of the fats, is due to failure of the pancreas to perform its functions, and will assist in doubtful cases in locating the lesion.

The bacteriological examination of the urine will differentiate certain surgical diseases of the bladder, and thus determine the necessary procedure according to the variety of bacteria that may be found.

The microscopical examination of the feces throws much light upon the conditions present in the upper part of the abdomen.

Connective tissue is digested in the stomach, while muscular fibres and fat are digested by the intestinal and pancreatic secretions. Their persistence in the feces in the lower bowel indicates the probable location of the disturbed function.

Blood, indicative of gastric or duodenal ulcer, may often be found by proper chemical tests in the feces even when "tar stools" are absent.

The examination of the stomach contents is widely used in differentiating diseases of

the stomach, and in determining the particular procedure in the individual case.

In addition to the ordinary chemical tests for acids we have the microscopical examination for various micro-organisms and atypical cells, and the examination with chemicals, and the X-ray for determining the size and motility of the stomach.

Then we have the study of rapidly hardened tissue sections to be made during the progress of an operation, to determine its extent, and the study of smears and exudates for the purpose of recognizing the particular infection that may be present.

The bacterial examination of the fluid aspirated from a joint will indicate whether, with a pure infection of the tubercle bacillus the joint may be treated by rest and extension, and fresh air after the manner of the orthopaedist; or with a mixed infection by wide incision, exsection and drainage after the manner of the general surgeon.

Allied with these examinations are those which are made with the aid of the Roentgen ray in diagnosing diseased conditions and surgical injuries, and in determining the particular operation necessary in the individual case.

Blood examinations, particularly the leucocyte count, and as we learn more of it, the differential count, are more and more of practical value to the surgeon; always remembering that leucocytosis is a measure of the resisting power of the individual and not of the severity of the inflammation, which is more likely to be shown by the differential count.

The diagnosis of abdominal inflammations from typhoid fever and from tuberculosis may often be made by the Widal test and the leucocyte count, particularly when combined with the diazo reaction in the urine. A low leucocyte count with a persistent Widal and a transitory diazo indicates typhoid, while a high leucocyte count,—the other signs being negative—points to some inflammatory disease such as appendicitis, and a persistent diazo reaction with a transitory Widal and a low leucocyte count suggests tubercular peritonitis.

Again in typhoid fever with perforation the favorable time for operation will be when the blood count shows that the leucocytosis is steadily increasing. Our knowledge of the value of the blood count has recently been summed up by Dr. Charles Laydon Gibson in the April "Annals of Surgery."

Dr. Gibson says:—"The differential blood count and its relation to the total leucocytosis is to-day the most valuable diagnostic

and prognostic aid in acute surgical diseases that is furnished by any of the methods of blood examination. It is of value chiefly in indicating fairly consistently the existence of suppuration or gangrene, as evidenced by an increase of the polynuclear cells disproportionately high as compared to the total leucocytosis. The greater the disproportion the surer are the findings, and in extreme disproportions the method has proved itself practically infallible. As the relative disproportion between the leucocytosis and the percentage of polynuclear cells is of so much more value than the findings based on a leucocyte count alone, this latter method should be abandoned in favor of the newer and more reliable procedure.

The negative findings, showing no relative increase or even an actual decrease of the proportion of the polynuclear cells, while of less value, show with rare exceptions, the absence of the severer forms of inflammation."

The estimation of the percentage of hemoglobin present in the blood is a guide to the advisability of operating in a given case. The rule has been to postpone operation when the hemoglobin is below 30 per cent. I think that an exception should be made in acute anaemias resulting from severe hemorrhage. It is always right to operate in order to tie a bleeding artery, no matter how exsanguinated a patient may be. That this is true is shown by our results in operations for ruptured ectopic pregnancies.

One of the most interesting of all the aids that scientific medicine has devised for ascertaining the physical condition of the patient is, the determination of the state of the organs of circulation, and the particular information that is brought out by the examination of the tension of the blood vessels. The study of blood pressure in reference to surgical diseases and surgical procedures, which has been so ably conducted by Crile and Cushing is of great interest.

Surgical shock and collapse has been demonstrated to be due to vaso-motor paralysis causing lack of peripheral tension, rather than to cardiac paralysis. The indications for treatment are therefore more defined, and instead of the random routine method of jamming in all the so-called heart stimulants that one can get into one's hypodermic syringe, when treating a case of shock; it is very clearly indicated that the first and most important remedy is adrenalin, best given in salt solution; a procedure in the use of which clinical experience has anticipated and corroborated theoretical

suggestion. In addition we may use strychnia and digitalin, but nitroglycerine and the nitrites are positively contraindicated.

Again, examination of the blood pressure during operation has been suggested and practised. Unusual susceptibility to the anaesthetic and the effects of long and severe operations may be anticipated and guarded against. When a sudden lowering of the blood pressure occurs during an operation the first remedy to be used is certainly adrenalin in small repeated doses, then strychnia in large doses. Only when there has been severe hemorrhage are we to use the saline infusions, which in vaso-motor paralysis are of little use, but which are of immense value when the collapse is due to empty blood vessels.

There is one point that I hold to be most important; salt solution should not be transfused into the body of a patient who is bleeding to death, until the open blood vessel has been closed. It has happened that a patient has had the little blood remaining in the veins washed out by too zealous a transfusion. My rule is adrenalin, ergotin and strychnia until the bleeding point is controlled, and then the saline.

With all these adjuvants to bring to his aid in diagnosis, with the terrors of sepsis almost eliminated by his technique, the modern surgeon is wonderfully equipped for his task.

I have called the present the age of surgery. I am not so sure but that forty years hence it will be considered the golden age of surgery.

There are unmistakable indications of great advances to be made in the near future in internal medicine. From the research laboratories are destined to come specifics which will remove from the domain of surgery many diseases which now furnish a fair proportion of our surgical work. Already antitoxin and intubation have taken from the surgeon the treatment of membranous croup, and relegated tracheotomy to the removal of foreign bodies, or as subsidiary to some more important operation on the head or neck.

When we have a specific for the cure of tuberculosis how much of our surgery will be rendered unnecessary. We have to remember, however, that the same thought has been voiced many times in the history of surgery. Many years ago, Bayer, in his work, "*Traite des Malades Chirurgicales*" (1814), said, that he believed "that surgery had reached perfection." Dupuytren is reported to have said that McDowell's initial

operation for ovariectomy was "the act of a man who should be indicted for manslaughter." Erichson twenty-five years ago said that "surgery had evidently reached its limits."

There are still many new fields to explore. Brain surgery, although as old as the science, is still far from being thoroughly exploited, while the surgery of the respiratory apparatus is only in its infancy. There are many things to improve in our operating work itself, while asepsis is of vital importance, there are other factors in the problem that have not been enough considered. The patient himself, his temperament, his mental attitude towards his own condition and the proposed operation.

I recall a patient before the days of aseptic operations who sustained an amputation of the arm for a crushed hand. The old fellow made what would be called now an uneventful recovery, primary union and no temperature. We were all surprised by the philosophical attitude of the man, until he explained that as a result of the loss of his hand the company would have to promote him from a dollar-a-day job to one with more wages.

Rapidity of operation—the least possible amount of anaesthetic—the avoidance of cold and exposure on the operating table, are factors which are of great importance in the recovery of the patient.

Professor Osler tells of the opinion expressed by a noted anatomist of the early part of the last century, who stated that the whole field of anatomical knowledge had been garnered and so thoroughly gleaned that there were only a few kernels left to be picked up by the "geese" who now represent the searchers after anatomical truth, and yet says Osler "there were still the broad acres of biology which had not been touched."

So in surgery no one can presage what the future will give us. Much has to be learned and much forgotten before we can say, with Ambrose Paré, "I have so certainly attained the mark at which I aimed that antiquity may seem to have nothing wherein it may excel us, besides the glory of invention; nor posterity anything left but a certain small hope to add something, since it is easy to add to former inventions."

Do not give a good prognosis in cases of melan-
sarcoma of the fingers or toes, no matter how small the tumor may be, and no matter how high the amputation is performed. In the majority of cases these patients succumb to metastases.—
Amer. Jour. of Surgery.

PROPRIETARIES, PHYSICIANS AND PROPRIETIES.*

By Fred Miller Corwin, M. D.,
Bayonne, N. J.

One cannot look through many medical journals in these days without realizing that a battle royal is on, over the proprietary article, or more especially the "nostrum question," between a small handful of men on the one side, led by the *Journal of the American Medical Association*, and the Council on Pharmacy and Chemistry of the same, in the interest of the elevation of the profession of medicine, and on the other side the well organized, numerous, powerful and well equipped with money, hordes of manufacturers and promoters of the vast array of medical and pharmaceutical preparations, the proprietaries and nostrums of more or less merit—usually less—backed up by a large proportion of the leading and presumably honorable and scientific medical journals of the country, whose owners and publishers see in this controversy a formidable blow aimed at their very lucrative advertising business.

Gentlemen, the time seems to be ripe for us to bestir ourselves in this matter and indulge in a little introspection to find out where and how often we are playing into the hands of our foes. For I shall endeavor to show that each and every time we are beguiled into prescribing or recommending some nostrum, we are forging for ourselves the fetters of habit, which will in time place us entirely at their mercy, and find us enrolled in the army of the supporters of nostrums, humbugs and fakes of all kinds.

Having been asked by our president to prepare a paper for this meeting on nostrums, I want to say at the outset that in looking over many good articles on kindred topics that have been published in the past year I find the subject already very thoroughly written up. Hence, it will be difficult to write anything new or original. But if my paper serves to attract attention to the subject, stimulate the exchange of ideas, and perhaps place this subject before some of you in a stronger and better light, it will not have been written in vain.

Perhaps a few words as to definition of the terms we use may not be amiss. A "patent medicine" is one made under a patent granted at Washington for the combination

* Read before the Hudson County Medical Society.

of name and drugs or substances in it. Its composition being a matter of record in the patent office, and available to anyone who wishes it badly enough to spend a small fee, and the time and trouble to look it up, it is not literally a secret medicine. Practically, however, it is so, for very few people understand that fact, or care to take the trouble to find out about it. As in all "patents," the protection of the government expires after the lapse of a certain time, seventeen years, I believe. Other so-called patent medicines and nostrums are sold under a copyright, which, as I understand it, protects the owner in the use of a name, and such description as he cares to have included. These are secret remedies unless the formulæ are furnished. "Nostrum" is defined by the Standard Dictionary as "a medicine, the composition of which is kept secret"; hence, we see that the use of the word secret in connection with nostrum is superfluous.

A proprietary is any article or preparation made only by one party. It may or may not be secret, copyrighted or patented, but in the sense in which I shall use the word, as distinguished from nostrums, it will refer to articles or preparations, the composition or formula of which is given in sufficient detail to enable one to know what he is using, and to what to attribute any results, welcome or unwelcome, which may be observed.

There are many very meritorious and worthy articles in this class; articles which no wide-awake, up-to-date physician can afford to do without; but for every one of these meritorious preparations there are a dozen or more which have no valid claim for our consideration, and which would soon sink into a well merited oblivion but for the persistent and unblushing effrontery with which extravagant claims are made for them, and apparently substantiated by alleged testimonials from physicians of experience, who claim to have worked wonders with them. Occasionally we hear "Back to the Pharmacopoeia" sounded as a slogan, and it is a catchy phrase for a rallying cry; but after careful consideration I think we will be forced to admit that going back to the pharmacopoeia, while it would certainly end the controversy at once, is not a practicable proceeding.

While we should all of us familiarize ourselves with the pharmacopoeia, and while we could all of us follow its guidance to a much greater extent than we do, to the advantage of ourselves and our patients, it

is readily apparent that to adhere to the pharmacopoeia literally would be to block the wheels of progress. The pharmacopoeia is supposed to reflect the needs of the medical profession. If the profession took more interest in it, it might be made more comprehensive, and hence, perhaps, more useful. It gives no hint or criticism of the therapeutic value of its contents. It simply sets up a definition of the articles admitted, and a standard of their quality and strength. In the last edition (8th Decennial Revision) published less than a year ago, as in all other editions, are many new articles. Now if we examine some of these we shall find under a chemical name, if a chemical, or a proper pharmaceutical designation, if a mixture, a number of drugs and preparations, which have been and still are sold under a variety of trade names, generally coined words, often referring to some supposed therapeutic property of the article. One example will illustrate:

Hexamethylenamine now official, has been for several years and still is, advertised and sold as cystogen, cystamine urotropine, uritone, hexamine, formin, aminoform, ammonio-formaldehyde, and, perhaps, other names. No doubt some gentlemen present were very certain that cystogen was superior to urotropine, or vice versa. Which did you prefer? Why was hexamethylenamine added to the Pharmacopoeia? Because the medical profession had tried it as a proprietary under these different names and found it to be useful.

The first United States Pharmacopoeia was issued in 1820 and the work has increased with each decennial revision. There were one hundred and seventeen additions made at the last revision. They were made because physicians in various parts of the country had tried remedies not yet in the pharmacopoeia and found them of sufficient merit to entitle them to admission. Perhaps some of them will be dropped in the next revision, but many of them will no doubt outlive anyone who hears this paper read to-night and continue to demonstrate their usefulness for many years to come. "Go back to the Pharmacopoeia." By all means. Use its official remedies wherever you can, and if in the next few years you are tempted to use some new unofficial remedy, which you must sometimes do, first be sure that it is not some one of our tried and well-known pharmacopoeial remedies perhaps slightly disguised and exploited under a fictitious name.

To my mind the task in regard to the

use of the unofficial drugs; the nostrums and the proprietaries; is to winnow away the bushels of chaff from the few kernels of useful grain, the truth.

How are we to do this?

"Knowledge is power."

I am inclined to place the blame for much of the facility with which physicians are led into the use of these nostrums upon a deficient education and knowledge of materia medica and pharmacology. Students in our medical colleges are so much more concerned with what seem to them more important and perhaps more interesting branches, that materia medica and therapeutics do not receive the attention which they demand and merit.

Of course I cannot expect all of you to go back and take another college course, nor do I flatter myself that my remarks on this subject will greatly alter the curriculum of any of our medical schools. But I can make a suggestion which is practicable for anyone who needs it, young or old, and that is that you take up the drugs, one by one, which you are inclined to consider useful and study them carefully, making yourself thoroughly familiar with them and their preparations. The task will not be a gigantic one. The United States Pharmacopoeia and the shelves of a prosperous pharmacy present a multitudinous and discouraging array of drugs and pharmaceuticals; but do not let them worry you. They are not all for you or any one person. Most of them are for the laity anyway. I once read somewhere an interesting and instructive article giving the number of words in our language used by the different classes of people, varying from the two or three hundred used by the ignorant and uneducated person in the lowest social stratum up to as many thousand, made use of by the highly educated, versatile, prolific and voluminous writers, authors and orators; even the higher number being but a small fraction of the words contained in a complete dictionary. So it is with our materia medica.

Make yourself thoroughly familiar with the properties of thirty or forty useful drugs, if you can find that many, and their most palatable and convenient preparations. Half that many will do very well. Go into your favored drug store and talk to some up-to-date pharmacist. Do not fear that you will be exposing your ignorance, "giving yourself away," as it were. He already knows from your prescriptions that you could advantageously learn consider-

able about drugs. He will be ready to assist you, and the exhibition of confidence in him on your part; the admission that you do not know it all, and would like to know more of what he knows about the remedies, you would like to use, will only serve to elevate you in his esteem, and the better understanding of each other will be mutually beneficial.

Then after diagnosing your patient's case you will know what to give and will not be tempted to write for Seng, Sanmetto, Antiphlogistine, Cactina, Pillets, Aletris Cordial or Gray's Glycerine Tonic.

These names suggest to my mind another point, and that is the terseness and convenience of them. A very craftily designed and warily laid snare to entangle you, but gentlemen, do not get too *busy*, or too lazy and indolent, to write for what you want in a manner which leaves you free, as a bird in the air, to turn whichever way you will and adapt your prescription to the needs of the case before you, as you interpret it, rather than to be bound down like a locomotive or a trolley car on a track which can only go one way and has no alternative but to go or to stop. The use of such preparations is certainly subversive of that fine sense of discernment and discrimination which should characterize a member of a learned profession like ours, and of that free exercise of a man's mental faculties which is desirable to keep him at his best. We all know that nerves and muscles and all the organs of the body must be exercised and kept in practice to do good work. What would become of the skilful, expressive and delicate touch of an accomplished pianist if he should grind out all his music with a pianola for five or ten years? I think some of the pianola advertisements claim that they do it. But! do you believe it?

And speaking of advertisements. Here is the root of the evil, and an active, vigorous and hardy root it is. More omnipresent and diffused than bacteria, more tenacious than the bacterial spores. I presume you know that there is a national association called The Proprietary Association already formed to look after the interests of the fake promoters. It is pleasant to contemplate that this association is endeavoring to control, not only the advertising pages, but the editorial and news columns as well, of some of our oldest, most widely circulated and (heretofore considered) respectable and ethical journals. I do not now refer to such periodicals as the *Medical Brief*, the *Od Quarterly*, etc.

It looks as if the *Medical Record* and journals of that class were to be enrolled against us, for as long as they continue to publish nostrum advertisements, they are not likely to be permitted to print original articles which denounce the nostrums, or to call attention to their fake character editorially.

The *Journal of the American Medical Association* has announced that it declines to publish advertisements of any proprietary or nostrum, the formula of which is not furnished. *American Medicine*, many of the State Society journals, and perhaps some other periodicals, are taking the same stand.

I believe this to be a very good line along which to entrench ourselves. It is a government requirement already in some other countries, and with a united effort on the part of the profession it may before many years be so here.

As a result of the efforts and exposés of the *Ladies' Home Journal*, *Collier's Weekly* and perhaps other lay periodicals, bills are being introduced into some of our State legislatures, requiring that the exact formula be published on the wrappers and labels of all patent and copyrighted medicines.

This will concern the laity perhaps, but it is a move of vast and far-reaching importance to our profession also, and we are in favor of it. What a sad state of affairs for our ardent, and often worthy, temperance agitators if they can no longer take their favorite "bitters" without that horrid percentage of alcohol staring them in the face. You say, "Poor chaps, they have been sadly deluded." But, gentlemen, what will you say about yourselves and some of your confreres, when you learn the formula of some of the nostrums you have been prescribing, and find out that you have been compelling your patients to buy some of the commonest of drugs which could have been furnished under their rightful names by any pharmacist for much less money, and that the biggest part of that money would have stayed right in your own town and benefited your druggist friend instead of going to swell the bank account of some wealthy fake promoter in a distant city and furnish the Proprietary Association with the wherewithal to subsidize the editorial columns of our leading medical journals, and stifle legislation which we demand in the interests of the public and ourselves, but which they know to be adverse to their interests?

I do not know whether it is a widely quoted aphorism or not. But the expression "Believe nothing that you hear and only half what you see" occurs to me. This must have been said before the days of printer's ink, or at least before the advent of the modern advertisement writer, for from the readiness of some people, lay and professional, to pin their faith absolutely to anything that they read in print, we might argue that there was a time in the early history of printing when the printers had that reverence for their art, that they would not permit their types to tell anything but the truth, and that this idea has been transmitted along with some other mental characteristics of the dark ages.

Certainly we cannot believe half what we see in print nowadays about nostrums, and as I write this I am not thinking solely of the advertising columns of the journals.

In opening your mail a pamphlet, presumably a reprint, comes to hand. You do not recognize the author as a friend, or one you know of by reputation even. It may be entitled, we will say, "The Multiple Phases of Anaemia." As you scan the pages you will review what you studied in your text-books. It will not hurt you to freshen up your mind in this manner, and soon you come to "Case I." Never mind now the family history and symptoms, but pass hastily to the latter part of the story, and if you find that Corwin's cast iron nest eggs (*ferri ova*) effected a cure in two months or so "with the aid of a liberal diet and regulation of the bowels" throw away the pamphlet and forget all but the review.

Our mail is overburdened with such trash. But what literature and advertisements may we put faith in? What unofficial remedies may we try?

There is a class of literature, leaflets, pamphlets or monographs, distributed by manufacturing chemists like Merck, Squibb, Malinckrodt, Merrell & Co., Powers & Weightman, and others, and manufacturing pharmacists like Parke, Davis & Co., Mulford, Wyeth, Bullock & Crenshaw, Sharpe & Dohme, Wm. R. Warner & Co., etc. Houses that make up a full line of pharmaceutical preparations, and a large line of pills and tablets not official. Some of these houses, perhaps all, maintain large research laboratories, equipped with complete and costly apparatus, presided over by well-paid and able men, for the purpose of determining and, if possible, increasing the efficiency of the products which are sold under their name. Specialties, i. e., pro-

prietary, each one of these houses may have, inasmuch as they make up some chemical preparations which are not made by the others. But they are not secret formula specialties, and for their therapeutic properties and value, no preposterous claims are made. They are not vaunted as cure-alls for nearly everything, but are recommended as reliable and agreeable preparations, of highest attainable efficiency, of remedies with whose action and effects the physician is assumed to be familiar.

If attention is called to a new remedy or combination of remedies, their physiological actions and properties are enumerated in text-book style and consistency. I believe every progressive physician would do well to make use of literature of this kind, just as I believe he should ignore the journals, journal articles and alleged reprints, exploiting secret remedies whether patented, copyrighted or not, and for which exaggerated and preposterous claims are made.

We may properly experiment with any preparation, the formula of which is given with sufficient detail to enable us to know what we are using, and to what ingredients we are to attribute any results or symptoms which may be produced in different patients. If put forth by a well-equipped and well-known manufacturing pharmaceutical house, which makes a large line of preparations and has a reputation for its products and for integrity of purpose and fair dealing with the profession to maintain and protect, so much the better.

We may try any new synthetic chemical product coming from the laboratory of widely known chemical houses, like Merck, Squibb, Malinckrodt, Merrell and others, who make up a general line of chemicals, but this does not mean everything "made in Germany" or to whose testimonials the name of a "Herr Professor" is attached.

Scan with suspicion, or better yet, ignore altogether the preparations of secret composition, and the alleged synthetics put out by some unknown house which exists solely for the purpose of making and selling a few specialties.

It requires no argument, if we will reflect a little, to show that it was only when the ancient medicine men got too busy in other ways to prepare their own medicines, that they had assistants to do this for them. Hence the pharmacists, and by another step in the specialization process came the manufacturing pharmacist with his proprietaries. Hence the latter is still, or should be, only our assistant. Now our code of ethics

demand that we as physicians make public among ourselves any formula we advocate; any remedy we find of use. The progress of medical science would never have been what it is to-day, even the nostrum fakirs would not have the little knowledge of drugs which serves their purpose, without that free interchange of ideas, without which there could be no progress. What shall we say therefore of our assistants? Of the men who owe to us the very existence of their business; who have availed themselves freely of our stores of knowledge, and who are dependent on us for their livelihood and profit, if they will not extend to us the same courtesy?

These articles of secret composition, which we are asked to use, are no more worthy of our confidence and patronage than are the so-called patent medicines which are advertised to the laity as cures for every known ailment.

It is my endeavor, and my advice also, to shun all proprietary articles which, while perhaps in themselves unobjectionable, have been exploited and marketed in such a way as to become well known to the general public, and to be found in the department stores along with Peruna, Scott's Emulsion, Lydia Pinkham's, Beef, Wine and Iron, Wampoles & Hagees (alleged) Cod Liver Oil, etc., etc., and Gude's Pepto-mangan.

The surface of this old earth of ours has now been so carefully raked over by the searchers for the useful that it is pretty safe to assume that about all the plants and trees and minerals, of any known or supposed therapeutic value, have been brought to our laboratories and made to yield up their active principles for our use, so we may well look with suspicion on any alleged preparation of a hitherto unknown plant with synthetics the case is different.

There will never be an end to the activity of the manufacturing chemist, or the flood of real and alleged synthetic articles, and the same may be said as to the biological departments of our large houses and their products. And here I must confess that I think we are very much at the mercy of the manufacturers themselves, unless the Council on Pharmacy and Chemistry of the American Medical Association can come to our aid. If, however, we accept only the products of well-known houses with numerous interests at stake, who do not exploit their products in an unethical manner, we will make the least number of mistakes, and be the least often misled into wasting time over worthless drugs.

In closing, I would like to mention a few nostrums which have obtained a hold on some portion of the profession, and have attracted the attention of the Pharmacy Revision Commission, or the large manufacturing houses, so that they may now be supplanted by official, or at least, non-secret preparations.

I have already told you about hexamethylenamine, and what it supplants. In benzo-sulphinidum we have the well-known saccharin, known also as sacchoral, saccharinol and saccharose, and which is, as might be supposed, a constituent of antidiabetin. Bismuth subgallate was first known as dermatol, and, I believe, precipitated a law suit. Those who think they cannot do without antiphlogistine should try cataplasma kaolini. Liquor cresoli saponificatus or compositus is practically identical with lysol; similar to but better than the creolins, and a large number of similar compounds on the market under fanciful names. Liquor antisepticus will replace disinfectol, entro-cresol, streptocal, listerine, borolyptol, etc. Every manufacturing house, and even Mack in New York put out a similar formula, although I doubt if many of them contain as much alcohol as this (25%).

If any of my hearers are in the habit of prescribing sanmetto, chionia, seng, tongaline, Hayden's viburnum compound, peptomangan, (Gude,) castoria, lithiated hydrangea, celerina, unguentine or resinol, I will only add that you do not need to, even if you consider them valuable preparations, for the lists of any of the large manufacturing pharmacists will furnish you with similar articles, which are not open to the objection of secrecy as to their formulae.

SOME OF THE CAUSES OF IRRITATIVE COUGH.

By J. Watson Martindale, M. D.
Camden, N. J.

Mr. President and Gentlemen:—When I was called on to read a paper before this society, I was at a loss to find a subject. Most of the gentlemen who have preceded me this winter have been specialists in some particular branch, and have been thus well prepared to read a paper on the subject of which they have made a specialty. I am a general practitioner, treating everything from a broken head to a broken heart, and there is no one subject on which I feel that I could speak with especial authority.

While pondering on the matter, a man

came into my office asking advice about a cough he was suffering from. He said he was afraid he was going into consumption; he had suffered from the cough for two years—it was worse at night, and he suffered from severe pains in the chest. I asked him if he had lost much weight in the last two years; he replied in the negative. He had not suffered from night sweats. There had been no family history of phthisis, no history of contagion, and none of the physical signs of phthisis were present. Upon depressing the tongue and looking into the throat the cause was plain. His uvula was very much elongated and the soft palate and adjacent structures were in a very high state of inflammation. Upon questioning him further, I found that he was a team driver and had a pipe in his mouth from 7 o'clock in the morning to 10 o'clock at night, only removing the pipe to take his meals. I suggested giving up tobacco and at the same time gave him an astringent gargle. In a few days he returned with the cough greatly lessened and the inflammatory condition of the fauces almost gone. In a short time, I expect the cough will entirely disappear. This man had taken innumerable bottles of cough medicine.—Piso's consumption cure, Scott's emulsion of cod liver oil, etc., without any benefit. It occurred to me that this was a subject on which I had seen about as much as any other, and I then decided to say a few words on some of the causes of irritative cough. I didn't say "the causes of irritative cough," but merely "some of the causes," as I was sure the gentlemen of the society would find a good many causes that I did not think of and would promptly call them to my attention.

A few years ago I was attending the wife of a saloon keeper who was suffering from peritonitis. There was nothing particularly serious about the case. One day a Christian scientist lady gained access to the room of the patient; she told the sufferer that she should not take any more doctor's medicine—she should put her trust in God, and buy two books from her (one of which cost \$3, and the other \$2.50), and the Christian scientists were to come and pray with her every day. "Now," she said, as she left, "if you do not take the help so freely offered, you will be worse to-night at mid-night." The patient was rather in favor of Christian science herself, but saloon-keepers are not, as a general rule, very much taken up with anything in the Christian line, whether it be scientific or not, and the consequence was that the husband did not allow his wife

to take the treatment. That night, at midnight, Mrs. T. was taken much worse,—so much so that the priest was summoned as well as myself. The man of God was the better sprinter and he had the patient shrived when I arrived on the scene. A hypodermic of morphine quieted the lady down, and she decided to stay on this mundane sphere a little longer. In a short time she was well.

As I left the house on my last visit I was hastily summoned to see a woman in the neighborhood, who was supposed to be very ill, and being ushered into the room of the patient, I was surprised to find the Christian scientist herself sick, and she said she felt very bad. She had a bad cough, palpitation of the heart, and pains all over her chest. She thought she had pneumonia. I asked her if she had prayed over the matter. She said she had. I asked her if she had read those two books (one of which cost \$3 and the other \$2.50). She said she had, but the matter had gotten beyond her. I saw some cigarettes half burned on the table. Upon questioning her, I found she had smoked a great many. A whisky bottle on the mantelpiece told a story of alcoholic gastritis. This woman was suffering from a cough caused by excessive cigarette smoking, and her heart was irritable from the same cause. She is to-day a leading exponent of Christian science in Chicago.

An erratic acquaintance of mine who has no love for physic or physicians told me that he had made a call a short time since to see a young lady who was suffering from bronchitis. She was under the care of a regular practitioner. This gentleman knew he was not a homeopath because there were not the proverbial two glasses of medicine standing on the table, and he was not an osteopath because there was the bottle of medicine with the doctor's name on the label and osteopaths do not give medicine. My informant noticed that the air of the sick room was very heavy; a thermometer was standing in the room and it registered 80 degrees Fahrenheit. The patient was coughing very severely. The mother said the doctor had ordered that there should be no draft as he was afraid Grace would catch more cold. After a few minutes the gentleman began to cough himself. They had a coal oil stove in the room to keep the temperature up and the windows were closed to keep the supply of oxygen down. The poor girl was nearly suffocated by the gas from the coal oil stove. My friend went to the window, opened it from the top, put out the

noxious coal oil stove and in a few minutes had the pleasure of seeing the girl experience some mitigation of the excessive cough. In some houses without a heater and with no stove-pipe hole for a small stove, I am in a quandary as to what to do with the patient. I would rather that a patient be in a cold room with a pure air than in a warm room saturated with the fumes from a coal oil stove or a gas radiator. Not only is the gas an irritant to the throat of the sufferer but the oxygen in the room is consumed by these agents. I have seen people shiver in a room at a temperature of 85 degrees heated by a gas heater. If these devices are used they should be placed near a window which has been slightly raised from the bottom and lowered from the top.

Some time ago a party came to see me who had been suffering from a severe cough for five years. He was a stationary engineer who did his own firing. As soon as he presented himself it was plain he was suffering from nasal stenosis. He was unable to get any air through the nasal passages. He was a mouth breather and the smoke and dust from the boiler was deposited in the back of the throat and gave rise to a continued irritation. His uvula was elongated, the soft palate injected and the back of the pharynx as well as the anterior and posterior pillars of the soft palate were in a highly inflamed state. The right nasal chamber was the seat of a bony spur and the opposite nostril showed an immensely hypertrophied turbinated bone, making a complete occlusion of both nostrils. Upon the removal of these obstructions, nasal breathing was reestablished, and in a short time the cough and accompanying catarrhal symptoms had entirely disappeared.

About nine years ago my attention was attracted to a child of four years who was suffering from asthma. This child's chest was distended until it seemed as if he was suffering from emphysema. He coughed half the night, and if he walked across the room his respirations became very stertorous. He could not play like other children, he had a poor appetite, coated tongue, heavy lethargic looking features, and presented the clinical picture of a mouth breather. His lungs were full of sonorous and sibilant rales, and his cough was accompanied by considerable muco-purulent expectoration. This boy had enlarged tonsils and was suffering from post nasal adenoids. I suggested operation. The family objected and suggested calling in a consultant. This was done. The consultant said the trouble was

the child's chest, as anyone could hear, the lungs were full of mucus. He suggested medicinal treatment and the boy was dosed with ammonium carbonate, ammonium iodide, belladonna, etc. At the expiration of six months his condition was worse; the chest had the typical bandbox note of emphysema and the boy was confined to his rooms and mostly to his couch.

I again suggested operation. This time the suggestion was adopted. The adenoids and hypertrophied tonsils were removed and nasal breathing established. I can positively assert that that child has never had an attack of asthma since the operation. He is a baseball player now and as sturdy a chap as you would wish to see.

Last summer I was consulted by a young lady who had suffered from a very severe cough which had persisted in spite of all treatment for a year. She was on the milk and egg treatment instituted for consumptives. She was taking cod liver oil and maltine, together with the syrup of hypophosphites. The history was that she had suffered from pneumonia a year previous and the cough of pneumonia had never left her. She was quite thin and anaemic and complained of pains in the chest, poor appetite, vomiting and an irritable cough. The thermometer showed no signs of an evening rise of temperature. There was no history of night sweats and there were no physical signs of phthisis present. A bacteriological examination was made, which was negative. Upon looking into the throat a very long, thin uvula was observed which dropped behind the tongue into the pharynx. This girl had been trying to cough up her uvula for a year. The uvula was amputated and the cough ceased in a few days.

Several years ago there were three young women in my neighborhood who were very fond of dancing. There was nothing wrong with any of them morally or physically at the time. They were just fond of dancing, and on every possible occasion they took opportunity to go to the dance hall. They attended the public dancing school and public balls several times a week. After a time I was consulted by one of these young women for a catarrhal condition which had developed recently. She was advised to keep out of the dance halls. The advice was disregarded; her cough grew worse. I examined the sputum and found tubercle bacilli present. In a short time she died of pulmonary tuberculosis. Shortly afterward the second member of the trio developed the disease and died. Within a year the

third member of the group came to me suffering from a violent cough. I suggested a discontinuance of the dancing. This party acquiesced; her cough continued for six months and finally she got well. In her case there were no tubercle bacilli present; although she had a cough of the same character as the first two.

If the observer will look over the heads of a company of dancers, in a large assembly room, he will see a dense haze of dust cast up by the feet of the dancers; even if the floors are waxed, more or less dust is carried in from the shoes, and it seems plain that the dust should cause an irritation and produce the cough which is nature's effort to rid the respiratory passages of substances which are irritant.

Apropos of this matter of dust; I have heard that a large percentage of the street cleaners of New York die of tuberculosis. Whether this is due to the dry tubercular sputum affecting a healthy lung, or whether the dust sets up a cough which inflames the respiratory tract and thus lowers its resist-ant force, I am not prepared to state.

An Irish girl went to see the doctor. She informed her friends that the doctor told her she had caught a cold in her "navel passages which had gone down to her barnacle tubes." The catarrhal inflammation of la grippe starts in the nasal passages and passes downward by an extension of the inflammatory process until it reaches the bronchial tubes and oftentimes it finds its way into the air cells of the lung causing catarrhal pneumonia. It also extends into the Eustachian tubes, causing earache, and frequently passes up through the lachrymal passages into the eyes, giving rise to conjunctivitis and other conditions of like character. Kyle is authority for the statement that a healthy individual will secrete half a pint of mucus from the nostrils in twenty-four hours. While this secretion is being poured out, the passage of air over the mucous membrane causes the fluid to evaporate, and even with this large amount of secretion, it is rarely necessary for a person in health to use a handkerchief. In case of an acute coryza the condition is entirely different. The infectious principle attacks the mucous membrane of the nose, which immediately becomes inflamed, and we have the three symptoms of inflammation, viz: calor, dolor, tumor. The swelling becomes so great that the turbinated bones come in contact with the nasal septum. Thus the evaporative process is stopped and the secretions find their way forward, scalding the anterior

nares, and at the same time some of the mucus finds its way backward, irritating the back of the throat and causing a distressing tickling cough. This cough is perhaps at first an effort to dislodge some tough, tenacious mucus from the back of the throat, which is later aggravated by the inflammatory condition of the uvula, pharynx and contiguous structures, which are swollen and edematous.

By using an atomizer with a mild antiseptic solution in the beginning of an acute inflammatory process in the nasal chambers, we can sometimes abort a serious illness or at least moderate its severity to a great extent.

What has been said with regard to the prophylactic effect of nasal treatment in la grippe also holds good in measles. I have frequently seen a case of measles with a very severe cough relieved in a short time by spraying the nose and establishing nasal breathing. The frequent use of the atomizer in measles and scarlet fever has been a potent factor in reducing the number of cases of middle ear disease, which are so common in those conditions.

A patient who had been an inmate of the White Haven Sanatorium remarked to me that he was surprised to find that cough was not a pronounced symptom among the inmates of the institution. In the morning some few of the patients had paroxysms of coughing, but as a general rule they coughed comparatively little. This was due to the fact that they were instructed to refrain from coughing as much as possible; and it is remarkable to what an extent the cough can be controlled by the patient. The very fact of coughing irritates the throat, and one paroxysm of coughing naturally superinduces another.

In the White Haven Sanatorium a patient who is suffering from excessive cough is generally put to bed and kept there until the cough is alleviated. Rest in bed is one of the most potent factors in relieving a cough. In pulmonary hemorrhage the cough is caused by the blood welling up into the bronchial tubes. By placing the patient in bed and giving him enough morphine to send him to sleep, the respiratory movements are quieted, the nervous condition of the patient controlled and the cough allayed, all of which conditions are favorable to the formation of a clot and the stopping of the hemorrhage. I shall not go into the coughs of bronchitis, pleurisy and pneumonia, as they are thoroughly dealt with in the text books.

In conclusion, I wish to say that the points in regard to treatment which I have described in this address are mostly the result of personal experience, and since I have been looking into the causation of these conditions, I have departed farther and farther from the nauseating cough syrups and expectorants, which, while they allay the cough more or less at the time, are prone to cause gastric trouble, and leave the patient in the condition of the poor woman in the Bible who suffered "many things of many physicians, and was no better, but rather worse."

2501 Federal street.

THE TREATMENT OF PULMONARY TUBERCULOSIS *

By

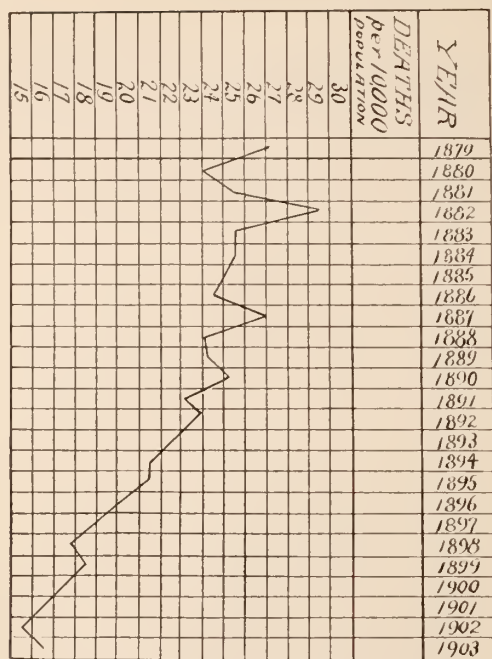
Theodore W. Corwin, M. D.
Newark, N. J.

During a few years past the management of cases of tuberculosis of the air passages has greatly interested me. I have carefully obtained notes of the origin and progress of a moderate number of cases which have permitted satisfactory observation, and I propose to draw upon these in support of what I shall say this evening.

As the subject of tuberculosis has many sides and the literature is voluminous, I can hope only to present a few limited aspects of it; but these will be of an entirely practical nature, and will refer particularly to the therapy, and the results. It may be pertinent to notice the general type of this disease now prevailing, as compared with earlier experiences.

Those of us who can look back for twenty-five years can remember how hopeless the prognosis was then considered. To say that a person had tuberculosis of his breathing tract was almost to sign his death warrant. I am inclined to think that the cases as we encountered them exhibited destructive lesions of greater activity than are observed to-day. The mortality statistics have shown a marked change for the better. Between 1860 and 1870 the mortality was about 40 per 1,000. The report of the State Board of Health for last year shows the marked decline in mortality since 1879, to the following graphic curve:

* Read before the Practitioner's Club of Newark, New Jersey.



Deaths from consumption in New Jersey for 25 years, per 10,000, from 1879 to 1903 inclusive.

Report New Jersey State Board of Health for 1904, page 28.

This remarkable decline certainly has great significance. It surely does not depend upon less accurate observation, for our methods are continually becoming more exact and comprehensive. My esteemed friend, Dr. Thomas W. Harvey, of Orange, in his address before the State Medical Society (1905), attributed this favorable change to a tendency of the disease itself to produce in our race an immunity against its ravages. He admitted, however, that the great advances in sanitation of the last few years tended materially to improve our resisting powers.

The speaker is inclined to lay more stress upon this latter influence and to attribute our present greater freedom from tuberculosis to greater care of the public health, with a consequent rise of the general average vitality and resisting power. While gladly acknowledging such blessings, we submit that there is still large opportunity for advancement in respect to measures, both public and private, for the promotion of the general health, and for the restoration or alleviation of the victims of tuberculosis.

We all too well know how many are being claimed yearly by this terrible agency; that one-seventh of our total mortality is thus caused, and that this means also the cutting short of one-third of all who are in the prime of life. We believe that the keynote of the progress in the treatment of

individual sufferers is again the promotion of the vitality of the individual; and that whatever more direct method of attacking the infection may be devised in future, our efforts in advancing the general vigor along hygienic lines will never become less necessary, or less effective. We observe that increasing success to-day is being attained more by close application to the details of correcting the care and conduct of our patients than by the use of new agencies.

We find that the present habits of living are still far from being hygienic—that they fail to promote and develop the body and to increase the vitality, the capacity and the resisting powers of the individual—that while many advances have been made, many defects still remain. We find that such defects are so serious that their radical elimination means almost a revolution as regards many ideas and practices. We find that for the most complete realization of our purposes it is necessary to absolutely withdraw our patients for a time at least from their customary environments, and to thereby break many ties which they have grown to hold as dear and precious.

Thus it has come about that sanatoria have been established with surroundings arranged with an eye single to the physical welfare, and with the old faulty associations out of sight. Thus an almost immediate uplift is accomplished and new and wholesome habits can more readily be begun. While sanatorium treatment, properly carried out, is ideal in many respects, and should be resorted to as far as practicable, we know that these institutions are at the present time beyond the reach of many who claim our advice and care. The occurrence of consumption in large measure among bread winners, and especially among such of them as have not been able to save up for a rainy day, makes the problem of providing for them very difficult.

But even the special sanatorium should not constitute our highest ideal, for we should not be satisfied until every home is a sanatorium. We may stop with nothing short of this. Our duty impels us to prevent disease even more than to remove it, and the promotion of health usually constitutes also our surest means of combating disease. Thus it is that drugs have been in large measure discarded in the management of tuberculosis and that the adaptation of hygienic, sanitary measures to the particular individual needs of each case must obtain the bulk of our attention.

With this in mind, the methods of treat-

ment are in general such as tend best to maintain and promote the health of any person. As it may seem, and is, a sort of pleonasm to speak of making well folks more healthy, I feel free to say bluntly that there are no entirely healthy persons in Newark to-day, with perhaps some rare exceptions, and the same applies to all other large cities. To say that the life or even the nutrition persists, in spite of many obstacles, is to give great credit indeed to our vital resistance; but it is not to say that we are well, for if a large percentage of our strength must be devoted to combating our bodily weakness and faulty environment, we shall have a proportionately less amount with which to grow and develop and branch out and bear fruit. We are not to be satisfied merely with the persistence of life, but must concern ourselves with its capacity for accomplishment after its individual wants have been supplied. Just as a community, engaged in conflict, can make no progress in commerce, arts and science until peace is established, so it is with our lives. If the conditions of ideal living be supplied us, we shall be better able to resist depressing influences and fight off disease.

We may summarize our endeavors under a few heads:

1st, To promote the great function of respiration, or, the supply of pure air to the body in sufficient quantities.

2nd, To advance the great function of nutrition, or, the supply of proper and easily digested food.

3rd, To provide abundant exposure to sunlight.

4th, To secure proper repose, and to regulate activity so that it shall conform to the bodily needs of the individual case.

5th, To protect the body from injury, including under this head exhaustion, of whatever kind; external poisons, such as foul air, germs, dust and gases, alcohol, coffee, tea, drugs and improper food, etc.; and internal poisons or toxins, such as result from indigestion, faulty elimination, degeneration, etc.

The importance of respiration has long been under-estimated in practice. Only recently have our needs in this respect received much attention. Respiration means simply the provision for supplying our body-cells with air. To say that the air should be pure and fresh, etc., would be quite unnecessary were its purity not so utterly disregarded in practice.

House air and fresh air are seldom inter-

changeable terms. The idea that the air by which we live should be fresh and free at all times, while accepted as a theory, is yet rejected in practice by the largest part of our community, not excluding some physicians. My father was long ago noted for his insistence upon living in fresh air, and was called a fresh air crank. Long ago he conducted fresh air through tubes from the windows to the beds of his consumptive patients. His ideas were much in advance of his day. Our fear of Nature has led us to adopt indoor lives. We all live indoors during much of our time.

This artifice has these disadvantages:

1st, It modifies our atmosphere. The air can no longer move freely. It is confined. It cannot renew itself. It is cut off from the great ocean in which it is born, in which it is purified, and from which it must be renewed. Its freshness cannot continue. We must therefore continually rebreathe some portions of it.

2nd, Another disadvantage of housing is that it keeps us out of the light. Compared with conditions outside, we live almost in darkness. Our windows admit but a small portion of what is our due. We are therefore deprived to a great extent of a very important agency of health.

3rd, Housing places us under numerous physical restraints. We should doubtless live and move in a larger way were we not hindered by so many walls. Who will doubt that such restraint dwarfs our development, our powers, and our pleasures?

Our constant endeavor must be to withdraw ourselves and our patients from these depravities, and to learn to live more and more in the open. The glorious light is breaking and old superstitions are being dissipated. Although not yet sufficiently recognized as being necessary for the maintenance of health, our dependence upon fresh, pure air in time of sickness is becoming generally acknowledged. Following the lead of the great Brehmer, in the management of tuberculosis, we have come to regard life in the open air as our mainstay.

The vital necessity of nutrition is conceded, largely, perhaps, because serious interference with it promptly disturbs our comfort or disables us. Tuberculosis is promoted by a deficiency in nutrition, whether due to want of proper food materials or to their imperfect digestion or absorption. The offering of food needs, however, to be regulated. Our palates as at present trained give no direct guide in

its selection, and the appetites of a large number of our patients are also depraved. In this rushing, busy age, we commonly eat in a hurry also. Mastication and insalivation are neglected, as well as repose afterward. Our nervous energy is so occupied with our affairs that the supply of it to our digestive organs is greatly stinted. Nervous exhaustion is one of the most constant forerunners as well as associates of the tubercular infection. It is seldom absent. The selection of food is commonly erroneous in some respects. The vast majority of patients acknowledge that they reject the fat of their meat, and at times they are found to have a distaste for such fats as milk, cream and butter. In practice we find it necessary to greatly augment the supply of fat. As far and as quickly as possible we should promote the habit of taking fat, and find that such a habit can usually be readily cultivated.

But we also find it of great importance to introduce fat very rapidly and in excess of the ordinary demands of the system. We commonly assist its digestion by artificial means under these circumstances. Cod liver oil, predigested or raw, has long been highly valued, and deserves its reputation. Many people, however, have such a repugnance to it that its free exhibition becomes difficult and may disturb the ingestion and digestion of other food. Often with increasing use, it continues obnoxious, and at best can only be tolerated. Its merit appears to be merely that of an easily digested fatty food. Consequently a substitute which should possess its nourishing qualities and be free from its objectionable ones has long been sought. I have found in the "Russell Emulsion of Fats" an efficient agent for the supply of this food principle. It is a matter of regret that its exact composition is withheld. We are told and may reasonably accept as true the statement that it is a mixture of several wholesome fats, and that by reason of its composite constitution does not readily become repugnant with increasing use. I have had, as I think, very gratifying results from this preparation, used conformably to Dr. Russell's directions, in conjunction with the free use of milk and butter, and other ordinary nutrients, given methodically, and to the limit of digestive ability. I was led to use it, after accepting the invitation of Dr. Russell to visit his clinic and his public hospital and observe for myself his methods and results. Dr. Russell was an interne at Charity Hospital in New York some twenty-

five years ago, and has since been connected with one of the large dispensaries of that city. I am not in full accord with Dr. Russell's method of introducing this remedy and believe that he is open to some criticism. The results, however, show that merit is present somewhere and must be recognized until more available means are offered us.

The value of free exposure to the light of the sun is well known, although not readily explainable. Such experience has long been recognized as of a tonic character. Later observations show that it proves germicidal to artificial cultures, notably those of the tubercle bacillus. Some authors believe that it exercises the same kind of influence upon germs circulating in the blood, when the body surface is exposed to its rays. The predominance of sunshiny weather constitutes the great advantage of some climates. As to climate in general, it is coming more and more to be recognized that far distant localities are unnecessary; and that such situations as afford the best opportunities for the patient to live out of doors are of most value. Evenness of temperature, dryness, protection from cold winds, and a moderate elevation are also valuable qualities. Treatment in towns, *ceteris paribus*, cannot be compared with out-of-town treatment.

Suitable conditions are readily available in many places in our own fair State. I have made many observations of the beneficial influences incident to the northern half of New Jersey. The seacoast or places nearby, as Lakewood, often prove most salutary, especially where cardiac power is below par.

As to exercise and repose in the treatment of tuberculosis: Bodily, and even mental, rest is undoubtedly most important, and as much required as in other pathologic conditions, e. g., typhoid fever, or nephritis, or a broken leg. This rule must be quite absolute in all acute conditions, as fever, exhaustion, rapid pulse, sleeplessness, etc., and when these are absent only such limited exercise as tends to promote healthy metabolism is permissible. More than this constitutes an added burden to an already crippled machine. The feelings of the patient are no guide, and he must be carefully guarded. Slight excesses are usually marked by a relapse into the above stated conditions.

Sleep is exceedingly important. I advise patients to retire as soon after the evening meal as possible, even at 7.30 or 8 P. M., and to sleep as long as possible—also to take a nap once or oftener during the day, whether

inclined to sleep or not. Patients are commonly very loath to observe this rule, but I believe it to be of the utmost value.

The protection of the body from such deleterious influences as stale air, foul air, germs, dust and gasses, cannot be mentioned in detail in the limited period allowed me to-night; but it must be remembered that in the management of any individual case all impediments to recovery should be most sedulously sought out and corrected. Regulated cool baths are important. Scrupulous cleanliness is necessary to prevent reinfection. This applies both to the person and to his surroundings.

Alcohol, tea, coffee and tobacco are considered harmful by almost common consent at the present time. Drugs should be almost altogether dispensed with, and especially all agencies which in the least degree tend to disturb the digestion. It is surprising how many annoyances can be remedied by natural or physical agencies without resort to drugging.

Of course, complications have often to be provided against, but it must be recognized that the digestive function is our sheet anchor and is to be sedulously safeguarded. Local measures are becoming available more and more in the treatment of this as of many other affections, and as these need not materially disturb the general system, they are quite permissible.

I have found tracheal injections of the greatest service, especially when tubercular deposit occurs in the larynx. I have repeatedly seen ulcerations heal entirely under such local treatment. The injection of quaiacol and menthol dissolved in albolene is often most comforting in ordinary lung cases, and the effects are very lasting. Argyrol, orthoform and lactic acid are very valuable agents.

It becomes evident, I think, even after this hasty and imperfect review of treatment that it will not do to simply direct a patient to go into the country or to some resort. He must be carefully instructed in all the details of the hygienic regulation of his habits and environment, and particularly as to his dangers. The house habits and the cooking, etc., of country people are no better, indeed are commonly much worse than those of city folk. Your patient must either go to a sanatorium or else be so in touch with you, or some other well qualified physician, that his regimen can be carefully and systematically scrutinized, corrected and modified, if we would get valuable results.

Clinical Department.

HOW I SUCCESSFULLY TREATED A CASE OF APPENDICITIS.

By Elihu Brittin Silvers, Rahway, N. J.

A neighbor having an undeniable attack of this disease declared he would not undergo an operation, but would trust to my medication. His refusal was so decided that individually I was compelled to yield—he was a personal friend—to his decision. I gave him a dose of calomel and followed it with a dose of castor oil, viz., a tablespoonful and 10 drops of turpentine (this last article always increases the operative power of the oil).

I had the bowels smeared frequently with a combination of equal parts of menthol powder, gum camphor and hydrated chloral, to assist in removing the local soreness. Kept the bowels bandaged with cotton flannel and fed him as I would an infant on peptonized milk, a small quantity every two or three hours, alternating with Horlick's malted milk. He was kept religiously on his back—the abdominal compress well adjusted. After two weeks of this lie still—keep the bowels still—in a word of not using that part of the alimentary canal and its associates—the party convalesced. As he approached convalescence he had a pain over the right hip radiating down that groin and I felt that there was gravel in the pelvis of the right kidney. I then gave him five grs. of salicylate of soda three times a day. He was at this time going about his upper rooms. As he grew stronger and could go out, which was soon, he desired to have the X-rays tried fearing as his progenitors were consumptive that he had either a tuberculous condition or a cancer of the mesenteric glands.

He was taken to Dr. Tansy, of New York City, who furnished a photograph, some 18 inches square, of the abdominal cavity, showing that the appendix had been inflamed. There was no trouble with the mesentery. Dr. Tansy wrote me that, as requested, he had looked for signs of gravel and found none. Within five days, the patient, who was still under the solvent treatment mentioned, brought me two small mulberry colored stones, one I kept, the other I sent to the photographer.

The theory under which I worked in treating the appendicitis was *positive* rest to the location affected. The food was carefully adjusted and, I forgot to say, that, if the slightest signs of gas forming appeared, elixer lacto-peptin was given. All the kinds of food he took I have stated. A part of my plan was, if I found it necessary, (if the local inflammation continued), was by an 18 inch soft rectal tube to slowly inject once daily or twice, or even more times if thought prudent, a saturated solution of boracic acid as an antiseptic.

I know that one swallow does not make a summer, yet I feel confident that what might be called a common sense treatment of this disease could often be tried with meritorious results. If I live long enough to treat other like cases, I shall further try this simple treatment.

Ascites in the presence of a mass in the pelvis usually, but not necessarily, means malignancy.—*Amer. Jour. of Surgery.*

Correspondence.

LONG BRANCH, N. J., May 28, 1906.

To the Editor of the JOURNAL:

SIR:—I see in your paper the statement that the city of Newark, N. J., is the only one in the state where the law is observed regarding the payment to the reporter of 10 cents for every case of contagious, infectious or communicable disease reported to the board of health. The city of Long Branch has done this for the past six years.

Respectfully yours,

JNO. W. BENNETT, M. D.,

President Long Branch Board of Health.

Book Review.

CLINICAL TREATISES ON THE PATHOLOGY AND THERAPY OF DISORDERS OF METABOLISM AND NUTRITION. By Professor Dr. Carl von Noorden, *Physician in Chief to the City Hospital, Frankfurt-on-Main.*

Part VII. Diabetes Mellitus. Its Pathological Chemistry and Treatment. Lectures delivered in the University and Bellevue Hospital Medical College, New York—Herter Lectureship Foundation—Edited by Boardman Reed, M. D. Translated by Florence Buchanan and I. Walker Hall. Small 8vo., 210 pages, \$1.50. New York, E. B. Treat & Company, 1905.

This welcome addition to the series of monographs, of which Professor von Noorden is the author, is a careful and timely presentation of an intricate and obscure, but always interesting disease. The perfect frankness with which the distinguished author handles his subject cannot fail to appeal to any scientific mind.

On page 17 he admits in his definition that we do not know the true nature of diabetes and on page 58 he says that we are ignorant of the exact constitution of glycogen, and on page 52 he says: "The diabetic individual has difficulty in making use of grape sugar (in metabolism) whatever its origin, and having recognized as highly probable that this anomaly of metabolism immediately depends upon defective formation of glycogen, we must approach the question as to what the deficient formation of glycogen depends upon. He who can answer this with certainty has solved the riddle of diabetes." In another place he tersely gives the gist of the matter by saying, "somehow or other the normal metabolism of carbohydrates is disturbed in the body of a diabetic."

On page 61 he depicts a condition of great interest, as follows: "There are cases in which only the consumption of sugar but not the synthesis of fat is impaired; obesity but no glycosuria is the result; it is a form of diabetes marked by obesity." A condition which Professor von Noorden prefers to call "diabetogenous obesity" rather than "lipogenous diabetes" which expresses the doctrine more usually held. "Certain of such people, in whom obesity was a hereditary family characteristic, although they could metabolise very large quantities of starch, exhibited marked alimentary glycosuria after the ingestion of 100 grammes of glucose." * * * "It is advisable, therefore, to test the urine of

obese people from time to time for alimentary glycosuria." On page 62 he says: "No organ of the body of a diabetic so frequently exhibits anatomical alterations as the pancreas, simple atrophy and sclerosis of the pancreas being the most frequent structural changes observed on autopsy. The specific diabetic disturbances of the pancreas are not necessarily connected with visible anatomical alterations in the islets or in any other tissue of the pancreas." In regard to the secondary effect evoked by the demand made upon the tissues for sugar, he says, (P. 67), "in the diabetic individual the tissue cells are bathed in a superfluity of sugar and are yet hungry for sugar because they are unable to utilize it."

The part of the monograph devoted to treatment is especially satisfactory. Amongst other things, he says it would be recognized if treatment were more prompt and more efficient "that there is hardly any other chronic disease in man which can be so readily controlled and whose dangerous tendencies are easier to direct. This does not apply—or only to a much smaller extent to the diabetes of children and young people, viz. up to about the end of the 3rd decade of life, even when the disease at the beginning seems ever so slight." These cases being, generally speaking, hopeless. Our author does not give much space to the discussion of drugs in diabetes. He says, "Since the infancy of our knowledge of diabetes, scientific medicine has always had to return to dietetic treatment," which is, of course, the principal, in fact the only satisfactory treatment. The chief reliance in Professor von Noorden's treatment is the individualization of the patient. Probably in no other disease is the necessity for this careful individual study of each patient so necessary nor its results so brilliant as in diabetes mellitus.

After the perusal of this excellent monograph we feel under a distinct sense of gratitude to Professor von Noorden for his admirable exposition of the present status of the knowledge of this interesting and important subject. The advance in the knowledge of this subject is a veritable advance in internal medicine and offers much encouragement for the future. It is only just to add that the work done in Professor von Noorden's laboratory has been of signal interest and value in this field. The translators of the monograph have done their work peculiarly well. The proof reading might have been better. A good index would have increased the value of the monograph.

Beer and Athletics. In commenting on the failure of the German competitors to distinguish themselves in the recent Olympian games at Athens, German writers have not hesitated to ascribe the incapacity of their country's representatives to the use of beer. The present instance is cited as another proof of the deleterious effect of beer drinking on muscular activity.—*Medical Record.*

Obesity a Disease. At a court in London the question recently came up whether corpulence were a disease or not. A patent medicine company was being prosecuted for selling an obesity cure without the revenue stamps, required on all proprietary remedies for any "disease, ailment or disorder." The magistrate ruled that obesity is a disorder and that the defendant had committed a breach of the law.—*Medical Record.*

THE JOURNAL

OF THE

Medical Society of New Jersey.

JULY, 1906.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any one failing to get the paper promptly will confer a favor upon the Publication Committee by notifying them of the fact.

All communications relating to the JOURNAL should be addressed to the Committee on Publication, 794 Broad street, Newark, N. J.

THE 140th ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY.

This meeting seems to have been the best in many respects in the Society's history. The attendance was, we believe, the largest so far recorded, reaching the number of 208 all told, which includes, we understand, a few guests and accredited delegates.

There was an excellent audience for every paper, far better than last year, and the papers themselves were, in our opinion, a distinct advance over the papers of previous years. There was also less random talking and less time wasted on the floor than heretofore. The orations were both excellent. The society, like every good thing, is steadily growing in strength and influence. Our members are to be congratulated on this fact.

We shall reserve comment on certain especial features of the society's work until after the proceedings have been printed. We hope and believe that every one who attended the meeting took home something to think about, and is even now planning to come to Cape May next year with something of value to tell his fellow members, and has already determined that he will do his part to make the 1907 meeting better than its predecessor.

The presiding officer and the various committees deserve much praise for the excellent way in which they did their work.

The results were assuredly gratifying and every one seemed to have derived both pleasure and profit from the occasion. The hotel accommodations were good and the situation charming. Cape May promises to do even better for the society. Let us all go there next year and induce all of our colleagues to go with us.

THE 57th ANNUAL SESSION OF THE AMERICAN MEDICAL ASSOCIATION.

The recent meeting of the National Association at Boston was indeed a memorable occasion. Over 4,700 members of the association registered and it is estimated that 1,200 or 1,300 more physicians who did not register were attracted to Boston by this great gathering, so that 6,000 medical men were assembled in the "Athens of America" last month. This is the largest collection of medical men ever assembled in the world, with possibly one or two exceptions.

Everything seems to have passed off with a smoothness and precision well nigh unprecedented. The best of harmony and good feeling prevailed. The cause of the universal brotherhood of all true medical men was greatly strengthened and a magnificent demonstration was afforded to the entire world of the solidarity, the influence and the altruistic spirit of the physicians of America.

FOURTH OF JULY.

As the anniversary of the national birthday approaches visions of powder burned urchins mutilated and injured in the glorious but somewhat idiotic celebration of the day come up in our minds. So long as every patriotic citizen shall inculcate in the mind of his innocent child the desire to indulge in the discharge of murderous weapons and the explosion of foul smelling and loud sounding crackers, bombs and torpedoes on this occasion, so long will serious wounds and injuries result to the child and his companions.

Our part is, of course, not to criticise

this incomprehensible method of showing patriotism and good citizenship, but to be prepared to treat the wounds and injuries in the most scientific manner. Owing to the great prevalence of the tetanus bacillus in the soil of the door yard and the ease with which these ragged and dirty wounds are infected with it, not to mention the fact that the bacillus is often found in the wads with which toy pistols are loaded, a certain number of cases of tetanus follow every Fourth of July celebration.

We believe therefore that those wounded on that day especially by toy pistols, toy cannons, etc., should receive injections of anti-tetanic serum as a matter of routine. Ten cubic centigrams should be injected immediately after the injury and the injection should be repeated in ten days. The wound should be thoroughly cleaned and good drainage established. Extensive incisions being made if necessary to insure this. For cleansing the wound probably nothing is better than peroxide of hydrogen. An anti-tetanic dusting powder has been highly recommended for a permanent dressing.

AN OBJECT LESSON.

Perhaps no object lesson is needed to impress on the profession the wonderful results of providing fresh air and cutting off artificial heat from the habitations of men or animals. To our mind, however, the problem has not as yet been so conclusively demonstrated that information for our future guidance and encouragement to persevere in our efforts to teach our patients the great truths involved are by any means superfluous.

The following account clipped from *Medicine*, for June '06, we think, cannot fail to interest our readers as it did us:

"A high death rate from tuberculosis among monkeys in confinement has been an accepted condition by keepers of zoölogical gardens for years. The monkey houses were always artificially heated in winter, in this way supposedly imitating the atmosphere of the tropics. The zoölogical collection in Lincoln Park, Chicago, had about fifty monkeys."

"The average life of the monkey (in this col-

lection) was from seven to twelve months; in some cases death taking place in a few weeks from a very rapid form of tuberculosis."

"Three years ago a change was instituted. The monkey house was not allowed to have a temperature above 50° and it communicated directly with the open air, and the monkeys were allowed out-of-doors all winter long. They are frequently to be seen sitting on little piles of snow and otherwise enjoying themselves in an atmosphere which is so foreign to their normal habitat. This change in the environment of the monkey has resulted in extinguishing tuberculosis from this particular group. Only three monkeys have died in the last year—two of them from traumatic causes, both fractures of the skull due to falls,—and another from some internal disorder, not connected with tuberculosis infection. No more conclusive experiment could have ever been made showing the value of the open-air treatment of tuberculosis."

There are other lessons to be learned from this recital beside that of the undoubted value of fresh air. Namely, that the artificial heat itself is probably a direct cause of tuberculosis. The peculiarly dry, devitalized air which is furnished to most American houses from the hot air furnaces and steam heaters is, in our opinion, distinctly injurious itself. We are not informed whether this Chicago monkey house was thoroughly disinfected or not, after the changes were made in it three years ago. Not that we fancy that such a performance would have made much difference in the result, nor are we aware whether other steps were taken to prevent infection. Whether they were or not, a remarkable change has taken place and it seems now possible to keep monkeys alive for years in confinement. A thing unheard of in the days of artificially heated and ill ventilated monkey houses. A condition, to which, we firmly believe, the injuriously dried and heated air, aside from any question of contagion, distinctly contributed.

Again, if monkeys do so well in Chicago in the winter in the open air, the question at once suggests itself whether our simian prototypes can not thrive in much colder climates than those in which we find them running wild. It seems probable that they live in the tropics, in great part at least, because the fruits and nuts upon which they feed are abundant throughout most of the year in

those regions, and not because they cannot survive a more rigorous climate.

Herein is another point of similarity to man, who thrives in a greater diversity of climates than any other inhabitant of the earth, whereas the monkey, our closest relative amongst animals, has heretofore been supposed to be able to flourish only in the tropics. A supposition which the experience just narrated seems to disprove.

"BACK TO NATURE."

What do we mean by the "open air treatment" of a disease? We use the term as though the physician actually did some tangible thing or made use of some therapeutic agent or agents especially under his control when he subjects his patients to this form of treatment. Perhaps the patient may imagine that the undoubted benefits which result from "the treatment" are due to the great skill of his medical adviser. Or if, as is often the case, he is taking some special form of fat or some peculiar preparation of creosote or some one's syrup of this or elixir of that, or using some inhaling apparatus, or some spray, or nebulizer, or gargle while undergoing the fresh air treatment, the credit for the improvement in his condition is apt to be given to the medicament or to the apparatus and the real curative agent is lost sight of or ignored.

Gradually, almost in spite of ourselves, the truth has forced itself upon us that the consumptive is, generally speaking, better off without drugs, and that the cures of this disease alleged to have been brought about by medicine of any sort have been effected in spite of it rather than by reason of it.

So anxious has the physician always been to provide a remedy, effect a cure or overcome a disease, that he has frequently forgotten that his first and most important duty is to remove all the injurious influences which may affect the case and give Nature a chance. The whole history of the treatment of consumption, when it shall have been finally written up, will show in the most impressive manner the futility of all human inventions, all therapeutic devices so long

as the laws of Nature are disregarded. "Back to Nature" must we go before we can make any headway in the management of this widespread and intractable malady.

In other words a treatment which would formerly have been esteemed no treatment at all is now our sole reliance. Fresh, pure, outdoor air, sunlight and properly selected food form the tripod upon which the entire modern treatment of consumption rests. Three essentials of healthful existence, to which the humblest living creature is fully entitled, comprise the epitome of the present therapy of this disease. Verily, the so-called weak things of the world have been chosen to confound the mighty. The relentless march of evolution throws down one elaborately reared and painfully thought out structure "of art and man's device" after another. There is no chapter in the history of human progress which affords a more instructive or valuable lesson than the evolution of the treatment of human tuberculosis.

DEFENSE AGAINST MALPRACTICE SUITS

The Illinois State Medical Society at their last meeting adopted a provision that the society should hereafter undertake the defence of any one of its members against a suit for malpractice. A similar provision has, we believe, been adopted by the Medical Society of the State of New York. At all events it was for a long time a valuable feature in the Medical Association of that State.

The question arises why it should not be adopted by the State of New Jersey. As has been frequently pointed out ninety per cent. of malpractice suits are brought against physicians through the machinations of unscrupulous lawyers, and these are, as a rule, quickly dropped when determined opposition is made by a competent attorney representing a State Society. In the remaining ten per cent., where there may be good ground for the suit, naturally the defendant will need and should enjoy the services of the best attorney that the State Society

can employ. Such suits are constantly increasing in numbers, and we should be just as well prepared to defend and protect our members as any other State Society.

Marriages.

Josiah Meigh, M. D., and Miss Nellie Blanche Smith, both of Bernardsville, N. J., were married at that place June 12.

Benjamin Van Doren Hedges, M. D., Plainfield, N. J., was married to Miss Adele Cutts Williams, of Washington, D. C., in Chicago, June 6.

Joseph Vincent Bergin, M. D., of Paterson, was married June 18 to Miss Kate Reynolds, daughter of Mr. and Mrs. John H. Reynolds, of the same place.

Frank B. Douohue, M. D., of Paterson, was married to Miss Bertha Agnes Burg, daughter of Mr. and Mrs. Charles Burg, of Clifton, on June 18.

Deaths.

W. Opdyke Selover, M. D., New York University, New York City, 1864, in 1888 mayor of Rahway, N. J., died at his home in Newark, May 21, aged 64.

Albert Toepfer, M. D., Göttingen, 1873, died at his home in Jersey City, May 18, from angina pectoris, after an illness of six weeks, aged 57.

John F. Edwards, M. D., New York University, New York City, 1848, died at his home in Raritan, N. J., May 23, aged 87.

Edgar Arthur Day, M. D., Long Island College Hospital, Brooklyn, N. Y., 1887, organizer of the Newfoundland (N. J.) Health Association, died at his home in Newfoundland, May 15, after a long illness. He was a member of the Brooklyn Gynecological and Pathological Societies.

William Hackett, M. D., Department of Medicine of the University of Pennsylvania, Philadelphia, 1860, of Highbridge, N. J., died in the Philadelphia Hospital May 19 from the effects of an overdose of morphine, aged 68.

Charles Warrenne Allen, M. D., College of Physicians and Surgeons, N. Y., 1878, died of typhoid fever at Gibraltar, May 30. He was a native of New Jersey and was born at Flemington, in 1854. His early education was obtained at Nantes, France, and at Phillips Academy at Exeter, N. H. He afterwards studied medicine at Harvard, graduating, however, in New York.

He was well-known as a specialist in dermatology and as a medical writer and teacher. He had a world wide reputation as an authority in radio-therapy. He was a cultured and genial gentleman, whose honorable and successful professional career reflected credit upon his name and upon his native state.

Circular 115 from the State Board of Health, on "The Prevention of Tuberculosis," has been issued for gratuitous distribution to health boards and physicians and through them to families in which consumption may be present.

News from the Counties.

CUMBERLAND COUNTY.

The annual meeting of the Cumberland County Medical Society was held at the Davis House, Port Morris, on Tuesday, April 10th. The officers elected for the coming year were: President, Dr. John H. Moore; vice-president, Dr. L. E. Bossert; secretary, Dr. S. L. Hand; treasurer, Dr. Joseph Tomlinson; reporter, Dr. S. M. Wilson.

Dr. Philip Marvel, of Atlantic City, counselor for the Fifth district, and Dr. J. M. Baldy, of Philadelphia, were present, the latter of whom read an interesting paper on "Uterine Carcinoma."

An interesting paper was also read by Dr. A. H. Mandel, of Millville. Subject, "Paresis of the Eye." The subject of osteopathy has been considerably discussed in the various meetings, and at the last term of court, a bill was found against Dr. J. C. Howell, an osteopath, of Vineland, for illegal practice of medicine. Unfortunately for the general good of the community, the jury failed to convict, and the matter rests without change.

Among the members of the county society who are in poor health at the present time is Dr. Henry W. Elmer, president of the State Medical Society, who has for more than a year been entirely incapacitated, on account of a seemingly incurable malady. Dr. S. E. Ewing, of Leesburg, four months ago had a severe attack of diphtheria, which has up to this time prevented his resuming practice, and Dr. S. D. Mayhew is at present in Bridgeton Hospital, having recently undergone an operation for appendicitis.

The Tri-county Medical Society consisting of members from Cumberland, Gloucester and Salem counties, held a regular meeting at the City Hotel, Bridgeton, on the afternoon of May 22nd. There were representatives present from each of the counties. An interesting and profitable paper on "Tuberculosis in Children" was read by Dr. L. M. Halsey, of Williamstown. A discussion of some reported cases brought forth quite a consensus of opinion favorable to the action of apocynum in the removal of dropsical effusion.

A well-ordered dinner at four o'clock brought the afternoon meeting to a close.

S. M. WILSON, *Reporter.*

ESSEX COUNTY.

The Nurses' Alumnae Association of the Newark City Hospital, gave a reception to the class of 1906 and their friends at the Nurses' Home, in the hospital, Tuesday evening, May 22d. An excellent program of music and recitation was rendered and dancing followed. The commencement was held on the following night and twenty-three graduates received their diplomas from the Board of Health. At a banquet given to all the nurses, May 21st, a tribute was rendered to the memory of Miss Margaret Scott who was fatally burned February 7, 1905, while on duty.

The Orange Memorial Hospital will receive \$250.00, to be appropriated to its new children's ward, from the Sunday School of the First Presbyterian Church. The management of the hospital itself, and of the training school for nurses, which have heretofore been distinct, have been united under one board. This has been done in order to meet certain legal enactments

which must be complied with before the training school can be registered in the State of New York. The estimated increase in the cost of maintaining the enlarged hospital combined with the training school will be \$12,000 a year.

On June 1st, the Newark Medical Library had 750 volumes on its shelves, of which 448 were from the library of the late Dr. Hewlett. These were selected from the doctor's books and were the choice volumes in his collection. The library receives regularly 40 of the best current periodicals.

MORRIS COUNTY.

The regular meeting of the Morris County Medical Society took place in the Savings Bank building in Morristown, June 12. Much important business was discussed. Especially in regard to the attitude of the profession in the matters of the fees for life insurance examinations.

SOMERSET COUNTY.

At a meeting of the physicians of Somerville, N. J., held June 8, 1906, the article from the June number of the JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY, entitled "Fees for Life Insurance Examinations," was read and the following resolution was adopted, formed into a pledge and signed:

We, the subscribers, physicians of Somerville, pledge ourselves to support the following resolution: "That it is the sense of the medical profession in Somerville, N. J., that no applicant for life insurance shall be examined for a less sum than \$5.00. This fee to be paid direct by the company. This resolution does not apply to industrial insurance, fraternal insurance nor to companies not requiring a physical examination."

UNION COUNTY.

The first annual dinner to the staff of the St. Elizabeth Hospital was held at the institution in South Broad street, Elizabeth, June 14. There were present Drs. E. J. Ill, of Newark; Victor Mravlag, James S. Green, Norton L. Wilson, T. E. Dolan, Stephen T. Quinn, J. H. P. Conover, Otto Wagner, Frederick N. Pierson, Arthur Stern, Charles H. Schlichter, Dennis R. McElhinney and M. A. Shangle.

MEDICAL SOCIETY OF WESTFIELD, N. J.

On Tuesday evening, May 29th, on invitation of Dr. Joseph B. Harrison, the physicians of Westfield met at his home to discuss matters pertaining to their mutual welfare. It was the sense of the meeting that a permanent organization be formed. After adjournment the doctors were handsomely entertained by Mrs. Harrison. On Wednesday evening, June 6th, the doctors again met at the home of Dr. Frederick A. Kinch, and completed the organization of "The Medical Society of Westfield, N. J.," having for its objects "social intercourse, mutual improvement, the protection and the regulation of the practice of medicine among its members." The membership is composed of the following physicians: Sherman Cooper, Joseph B. Harrison, Joseph E. Wright, Frederick A. Kinch, Robert R. Sinclair, William R. Tubbs, George S. Laird, H. H. Atkinson and

William B. VanAlstyne. The officers for the ensuing year are: Joseph B. Harrison, president; Frederick A. Kinch, vice-president; George S. Laird, secretary and treasurer. It is the purpose of the society to hold monthly meetings at the members offices or homes, when medical essays will be read, reports of cases presented and other matters of interest to the profession discussed.

ELIZABETH MEDICAL CLUB.

Reported by Theodore F. Livengood, M. D.,
Elizabeth, N. J.

A symposium on the treatment of pneumonia was held at the regular meeting of the club in May. Dr. N. L. Wilson occupied the chair. Speeches of five minutes length were allowed to those who had been assigned topics by the committee on papers.

Dr L. R. Brown spoke on "Dietetics in Pneumonia." He said the diet does not differ from that in other acute febrile conditions. However it is well to remember that the digestion is crippled by vitiated or scanty gastric juice, and abnormal pancreatic secretion and that the functions of all of the peptic glands are more or less perverted. Therefore food should be given in the most digestible form.

Drs. Whitehead, Green, T. F. Livengood and O'Reilly emphasized the opinion that in sthenic cases, for the first twenty-four hours, no food of any kind need be given, but plenty of water. Where there is nausea and vomiting all food should be withheld till the condition is changed. Milk, koumiss, broths and some of the meat extracts are valuable. The attending physician should give explicit instructions about the amount and kind of food to be given and the intervals between each feeding.

In regard to venesection and veratrum in the treatment of pneumonia, Dr. Donovan said that where the patient was robust and the arterial tension high he believed there was no other remedy which would so uniformly relieve the condition and avert death as general blood letting. He has used it in a number of cases with the happiest results and believes that the profession is prone to give up the remedies so highly lauded by Rush and his *confreres* without sufficient cause. Veratrum viride, cannot in his opinion, be substituted for venesection, and is a dangerous and uncalled-for remedy.

None of the other members of the club had any experience with these remedies and said they were not seeking any.

As to chloroform and creosote inhalations, Dr. A. R. Eton, Jr., said. "Both these remedies are said by their champions to inhibit the growth of the bacilli or cocci which we now believe are the cause of the disease. Their reasoning is illogical according to the pathological conditions which we know exist in pneumonia. Such agents must act directly through the smaller bronchial tubes or by absorption through the blood.

As the infected lung area is completely blocked, the bronchial tubes being closed with the exudation, and there is a complete blood stasis in the vessels, the remedies could not reach the disease by either route. As to ameliorating the general toxæmia, they are inert. Chloroform is a potent heart depressant and on that ground alone should be interdicted.

When to use and how to use strychnia, glonoin,

camphor and adrenalin, Dr. James S. Green said: "The indiscriminate use of any of these powerful remedies was in many cases not only useless, but positively harmful. So much had been published in our medical journals during the past five years about the efficacy of strychnia and glonoin in particular, that a number of our *confrères* came to regard them as positively essential to the successful treatment of pneumonia, and gave them religiously as soon as the diagnosis was made. To be of service, we must know the conditions for which they are indicated and then give them. Where the heart is weak strychnia would do good. Glonoin is indicated where there is tension of the arterioles and is one of our best vaso-dilators. Its effect is ephemeral and it must be given frequently to sustain the effect. Camphor is a good stimulant but objectionable to many patients. Adrenalin is a vaso-constrictor and promises much where there is great relaxation of the blood vessels and the heart's action is weakened because little resistance is offered to the arterial circulation. I have had no occasion to use adrenalin except as a local application where the field of operation would have been obscured by hemorrhage. Atropia is an excellent respiratory stimulant. In administering it we should remember that it often dries the secretions of the mouth and throat and makes the patient uncomfortable."

Dr. T. F. Livengood said: "The best way to give these remedies where we want to get their full therapeutic value, is hypodermatically. Given by way of the alimentary canal with its power of absorption at a minimum, we were often disappointed in the results and thought the drug inert when it was lying in the alimentary canal waiting for an opportunity to exert any action or was discharged with the excreta. When given hypodermatically we know that it is absorbed and can tell in a very short time what the action is going to be. Thus we are able to gauge the dose and to fix the intervals. Camphor can be given as suggested by Jacobi dissolved in almond oil. In this manner it is readily absorbed. In all asthenic cases camphor is indicated. While Wood and Shoemaker speak of it as differing so much in its action on different individuals as to make it an unreliable remedy. Stillé collected enough evidence to compel us to believe in its power. I have used it in a number of cases and found that it calms the nervous system and stimulates the heart and respiration. It is remarkable how our fears of the toxic action of strychnia have been dissipated in the past decade. As late as 1885 there were few of us sufficiently heroic to administer a dose of more than grain 1-20 and when to repeat it was a mooted question. Now in pneumonia cases we are ready to increase to gr. 1-10 every three or four hours, where we have a competent nurse to watch for physiological effects, some practitioners even report in desperate cases having given gr. 1-6 and tided the patient over the crisis. I believe we should lay more stress on atropine as a respiratory stimulant."

As to local chest applications, Dr. Dearborn said: "Since we are better acquainted with the etiology of pneumonia the uncomfortable, old flaxseed poultice which swathed the patient for weeks increasing the temperature probably, and at other times getting cold and clammy and making the patient feel miserable has been discarded by all progressive practitioners. If we are to believe the half that physicians are represented by the 'Antiphlogistine' 'Antithermoline' people as telling us, we could cure pneumonia without any other

remedy. Local applications do not at all influence the course of the disease."

Of coal tar derivatives and the salicylates, Dr. S. J. Keefe said: As antipyretics all of the coal tar products are dangerous. They are heart depressants and blood disorganizers, producing conditions which every physician is striving to avoid. Hydrotherapy would reduce temperature without depressing the patient. The salicylates, so much lauded by some of our clinicians, had been without value in his experience. Often they produced anorexia and in many instances nausea.

Concerning oxygen and ventilation, Dr. Horace R. Livengood said: "The people have seen oxygen used so often in *extremis* that they are now sure that it is a deadly weapon whose appearance is closely followed by the undertaker. The deadly oxygen tank is the name given it by those who 'don't know.' Oxygen is a very valuable remedy when there is cyanosis and often tides over a crisis. It should be administered without stint. Unfortunately it is expensive and on that account cannot always be procured. Ventilation is very necessary, but it is an error, in my opinion, to have the temperature of the room below zero as some practitioners advocate. The temperature of the room should not range lower than 65 degrees Fahr. Let the air be pure but warm."

In the treatment of convalescence, Dr. E. R. O'Reilly said he uses wine, chalybeates, quinine and strychnia. Best of all, if the patient can afford it, is a change of climate.

As to digitalis and strophanthus, Dr. Otto Wagner said, that, when the patient is an alcoholic, digitalis is the remedy *par excellence*. He does not consider it indicated as some physicians do, in all cases. Strophanthus is too transient in its effect.

What to do for delirium and tympanites, Dr. R. B. Whithead said: "If delirium is caused by hyperpyrexia, cold sponging and the ice cap should be employed. If due to toxæmia opiates and alcoholic stimulants should be tried. Sometimes hyosine-hydrobromate was successful. Chloral and the bromides would produce sleep. Of course, where a meningitis existed, there was small prospect of doing anything. Tympanitis he considers a grave omen, so far as prognosis is concerned, if the cause is not entirely due to indigestion. If indigestion is the cause, it can be relieved by cathartics and high enemata of turpentine and assafetida; but when due to nervous depression we must assist with strychnia and alcoholic stimulants. Its interference with respiration and heart action can sometimes be relieved by the introduction of a rectal tube."

Dr. Wilson spoke of the invasion of the ear by the pneumococcus and the treatment.

The gist of the general discussion which followed was that in the present state of our knowledge the treatment must necessarily be a treatment of symptoms. That probably in the near future a serum would be discovered which will enable us to combat the disease with as much success as we are now combating diphtheria; and that by an intelligent administration of the remedies now at our command we are able to so reinforce the powers of nature as to frequently get the patient past the crisis of this self limited disease successfully.

One druggist says physicians are as gullible as the laity. A live, up-to-date agent of a compounding house can sell them most anything.—*Jour. A. M. A.*

The Average Length of Practice of the American Physician.

—The necrology department of the *Journal of the American Medical Association* is probably as complete as any such department can be made. In it were recorded 2,045 deaths of physicians in the United States and Canada in 1905. There is an estimated medical population of 215,000, hence the rate of mortality is 16.36, not differing much from previous years; 14.74 in 1902; 13.73 in 1903, and 17.14 in 1904. It is astonishing that death, so unexpected in the individual, is so regular and constant in the mass. The youngest doctor reported was 23; probably there were younger men who died, but being so new in their profession their deaths were not forwarded. The oldest was 104, a fairly ripe age for a nerve racking profession. In practice the time varied from nothing to seventy-five years; there were five others who had practiced over seventy years. The average length of practice is thirty-one years and one month, quite a remarkable length considering the fact that so many physicians are exposed to death, disease, exposure, and exhaustion constantly. The nerve racking character of medical practice is seen in the list of causes of death, for heart disease in various phases leads all other causes with 202 cases. Cerebral hemorrhage is second, with 153 deaths; pneumonia, 141; tuberculosis, 102; nephritis, 100; senile debility, 80; accidents, 72; suicides, 46; typhoid fever, 41; malignant disease, 34; septicemia, 28; appendicitis, 27; etc. It is interesting to note the methods of suicide which show that no especial difference exists when the thought of self-destruction occurs. The introduction of new men into the profession is still greater than the outgo to a considerable proportion.—*The Medical Times*.

Death a Gradual Process.

—Edward Coles, in an address before the International Congress of Arts and Sciences, points out that there is no definite time at which life ceases and death begins in a complex organism, for one set of cell complexes may survive another for a long time; but "there is a gradual passage from normal life to complete death, which frequently begins to be noticeable during the course of a disease. Death is developed out of life." "Thus death does not come to the cell immediately, but is the end-result of a long series of processes which begin with an irreparable injury to the normal body and lead by degrees to a complete cessation of all vital phenomena." It is reasoned that "life and death are only the two end-results of a long series of changes which run their course successively in the organism"; also that "death undergoes a development; normal life upon the one hand and death upon the other are merely the remote end-stages in this development, and are united to one another by an uninterrupted series of intermediate degrees." This transition from life to death is termed *necrobiosis*, a word introduced into pathology by Virchow and Schultz; it is understood to mean, according to Verworn, "those processes that, beginning with an incurable lesion of the normal life, lead slowly or rapidly to unavoidable death."

A baby 51 weeks old, living at Mt. Holly, weighs 51 lbs., so the papers say. The mother weighs 120 lbs. The child is reported to have weighed 12 lbs. at birth and to be perfectly well in spite of its phenomenal weight.

MEDICAL PRACTICE IN PATAGONIA.

The dispensary of Patagonia knows but two remedies for the diseases of children—animal skins and common yellow clay, both to be used at the same time, whether the disease be in the head or feet of the little sufferer.

On being called to see a sick child, says London Answers, the Patagonian doctor takes with him a tight skin bag, opened at the larger end. Clay is plentiful everywhere. While some member of the family makes a thick batter of this yellow earth, the medicine man sits staring at the sick child or else shakes a painted rattle in an idiotic fashion before the little one's face.

When the plaster of clay is ready, the child is smeared from head to foot with it and then slipped feet first into the bag before mentioned. Should the child cease crying before this proceeding has been carried out it is thought to be a bad sign, an omen that the devil is still lurking in the child, but is keeping quiet for fear of punishment.

On the other hand, should the child become calm as he is being bagged the parents and medicine man think that the prince of darkness has left the body of the child in order to escape imprisonment. In the event of this last-named contingency arising, the skin bag is immediately closed and tied. The doctor then opens another bag and throws three pebbles and some serpent's teeth into it. These are well shaken for a moment, the idea being to get the devil to jump into the bag after the charm, whereupon it is instantly closed, tied and sunk in the nearest body of water.

After this rite has been carried out to the letter the bag in which the clay-besmeared child has been deposited may be opened. If the little one has not already been smothered by being confined in the bag during the incantations of the medicine man, it is thoroughly washed and wrapped in a clean, warm skin, the hide of a "muley" white bull killed in the new of the moon being preferable. Strange as it may seem, this treatment usually cures, the water being a prime factor in restoring health, no doubt.

Should death ensue, the doctor tells the bereaved parents that two devils were after the child, and that all the medical science in the world is not equal to the task of coping with two of the imps of the infernal regions.—*Evening News*.

If all the People in the United States

would at once begin chewing properly, three-quarters of the doctors would be put out of business. The patent medicine men would have to turn their factories to some more reputable use. Human life would soon be doubled in length, and nearly all the digestive maladies would disappear; and if the digestive disorders disappeared, Bright's disease, liver disease, consumption, and most other maladies would disappear also; for at least nine-tenths of all the chronic maladies from which human beings suffer, grow out of disordered digestion due to dietetic errors.—*J. H. Kellogg in Good Health*.

Here's to the stork,
A most valuable bird
That inhabits the residence districts;
He doesn't sing tunes,
Nor yield any plumes,
But he helps out the vital statistics.

—Portland Oregonian.

THE SONG OF THE PATENT.

I thought that my health was as good as the next,
But I learned that it was terribly bad;
For I found, after reading the newspaper text
Of a loud patent medicine ad,
That mushrooms were growing all over my liver,
That something was loose in my heart,
That due to my spleen all my nerves had turned
green

And my lungs were not doing their part.
I wrote Dr. Sharko and got as an answer,
"The wart on your thumb is incipient cancer."

I've taken Pe-ru-na for forty-nine days,
And Scamp Bark, my symptoms to gag;
And isn't it queer—all my pains disappear
When the medicine gives me a jag?
A "lovely sensation" I get from them all,
Which banishes carking annoy.
So gaily I drink 'em—and Lydia Pinkum
Has added her quota of joy.
And I've sent Dr. Bogie a neat little sum
For "radium tests" on the wart on my thumb.

When baby is restless a bottle I keep
Of Ma Winslow's Syrup. It takes
A spoonful of poison to put him to sleep
And another one when he awakes;
He lies in a paralyzed, hypnotized state;
So calm you can see at a glance
That the dear little chick sleeps as sound
When he's neatly laid out in a trance;
And I'm sure every mother could learn, if she
would,
The knock-out-drop method to keep baby good.

While reading bright essays on "wonderful cures"
In decent newspapers each day
I see all the symptoms our tired flesh endures
And fly to my drugs in dismay.
I've Liquozone, Fakezone stocked on my shelf
With Horner's Safe Waters of Life;
I'm taking three-fourths of the tippie myself
And giving the rest to the wife—
And if there is anything left after that
I give it to Admiral Togo, the cat.

So this testimonial I would indorse
To give all poor sufferers hope.
Much pain I've endured, but I'm "positive cured."
The baby has spasms, my wife's throwing fits,
And I'm feeling fuzzy and bad—
For I feel we've amassed all the symptoms at last,
Which you read in the medicine ad.
The ready-made cure and the angels who make it
Thus comfort and bless the poor devils who
take it.

Wallace Irwin, in Collier's Weekly.

The Graduates of the Monmouth Memorial Hospital Training School, at a meeting on April 4th organized an alumni society.

221 Deaths Per Day in New York.—Every day in that city, 221 persons die. In the first three months of 1906 the deaths numbered 19,926, averaging 1,550 a week. The births reached 2,000 a week. Diphtheria has killed 695 since January 1; measles, 503; scarlet fever, 141; cerebro spinal meningitis, 258. Diphtheria and measles have been unusually fatal. The death rate for the first three months of 1906 was 19.47 per 1,000—the lowest in the city's history.—*Evening News.*

Physiology up to Date.—After a lesson on digestion the teacher, anxious to know just how much her instruction had been understood, questioned the class. The first answer was rather discouraging, as the girl called upon made this startling statement: "Digestion begins in the mouth and ends in the big and little testament." It was the same teacher who received the following note: "Pleas teacher do not tel Mary any more about her incides it makes her so proud."—*Harper's Monthly Mag.*

Our Children.—We aspire to make our children better than ourselves. This, of course, can only be accomplished (following the dictum of our colleague, Oliver Wendell Holmes) by training ourselves as well as them. Now the most potent factor in good health and morality is the daily cold bath. This is worth practically as much as the "fragrance of the Morocco," in their education. It keeps their blood flowing more briskly. It avoids auto-intoxication and the consequent inhibition of every faculty and in general takes them out of the class of boors into that of gentlemen. It has made the English gentleman the envy of the world. It can make the children of the American physician the foremost gentlemen of their generation.—*The Journ. of the Kansas Medical Society.*

If we can devote ten thousand actions of the jaw daily to senseless or vicious gossip, what sense is there in denying adequate jaw service to the most important function of living?—*Horace Fletcher.*

In strapping the chest for fractured rib, two points should be particularly noted: 1. The straps should pass well beyond the median line. 2. They should be applied in full expiration. One or two straps passed over the shoulder help much to secure immobilization.—*Amer. Jour. of Surgery.*

The JOURNAL will be glad to print original papers from any source, preferably from members of the State Society, provided that they shall be of sufficient merit and shall be contributed to this paper exclusively.

Anonymous communications will not be published, but the name of the author of a communication will be kept secret if the editor is requested to do so.

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SYMPOSIUM ON NUTRITION DURING THE FIRST TWO YEARS OF LIFE.

At the 140th Annual Meeting of the
Medical Society of New Jersey.

NUTRITION DURING THE FIRST YEAR.

By Henry L. Coit, M. D., Newark, N. J.

Nutrition in early life is one of the widest fields for scientific investigation; it is one of the most urgent medical questions before the profession; and it is one of the most important economic problems presented to the human race.

The truths concerning it within our grasp are meagre when compared with the innumerable questions which yet remain unanswered. The problems involve the physiology of lactation; the physico-chemical relations of food and its nutritive values; the complex processes of digestion and assimilation; tissue waste; repair and growth; the adaptation of substitutes for the natural food of the infant; and how to avert the growing universal maternal failure and the consequent increasing infant mortality in most of the countries of the world. While some of these questions are very complex, as we are taught by the recent work of Mann on the chemistry of the proteids, yet we are making rapid strides toward a rational basis for our procedures.

Universal Failure of Maternal Feeding.

We are face to face with two great facts, namely: That there is in our race a wide-

spread maternal failure to perform the function of lactation; and, that there is a growing necessity for substitute feeding of the young during the first year of life.

That these facts are correlated in determining the alarming infant mortality in modern times can be demonstrated. We are therefore justified in trying to avert these consequences, to discredit and disallow, so far as we are able, the employment of any method of infant feeding which is irrational or unnatural. Artificial infant feeding ranks among the most far-reaching problems in medical science, involving the perpetuation of the race; and maternal infant feeding becomes an economic question of the greatest importance, which should be thoroughly studied by the physician.

There have been no reliable statistics thus far gathered from which we can determine what proportion of women, who give birth to healthy offspring, fail to nourish their infants; nor at what different periods of lactation different classes of women are unable to perform this function. It is the current opinion, which has no basis in fact, that the chief cause of maternal failure resides in some ill-defined influence which congested city life has upon the nervous system of women. While this may have a detrimental influence, the belief is wide of the mark, as there are probably very many active agents both remote and close at hand which limit and tend to destroy this function vital to mankind.

It is probable that those who will finally reveal the true causes of maternal failure will find them not alone in environment, ill-adapted climate, bad hygiene or strenuous living, but in all combined and which will

make necessary deeper researches into the physico-chemical processes of digestion, of digestive decomposition, of nervous waste, of nerve repair, of assimilation and auto-intoxication. They will also probably be found to involve the psychic relations of mental activity and its effect upon bodily functions, and the remedy, no doubt, will include a harmonious adjustment of mental work and mental rest, of bodily activities and physical repose.

It would seem, therefore, that we must revolutionize the life and habits of the race if we would restore this disappearing function, through the activities of which the foundations of our life were designed to be laid. Statistics on questions of this kind are chiefly made in large cities, and it is claimed for American cities that the proportion of women who fail to nurse their young during the first year is about sixty per cent. of the whole. This is probably a conservative estimate.

Escherich proposed a committee to formulate plans to promote breast feeding, because of the alarming infant mortality. He states that the percentage of breast fed infants in Berlin in 1885 decreased in five years from fifty-five per cent. to thirty-two per cent.; which means that sixty-eight per cent. were hand fed. As a commentary upon the theory that modern city life is a cause for this, I had an opportunity recently at a medical meeting to ask its president, who traveled in a radius of twenty-five miles in the country, what proportion of mothers in his section failed to nurse their infants by the third month, and he thoughtfully answered, seventy-five per cent.

The mothers of to-day seem to be able to do little more than furnish an entree in the diet of their babies, whereas, if it were needed at all, the bottle should be the entree, for, in order to agree, it must be a lighter dish than the ideal breast milk dinner. There is a popular opinion that most mothers seek to escape the duty of nursing their young. My experience teaches me that this is rarely true. It is an undeserved opprobrium. In the best of homes I find the evident desire and then, after all means to promote lactation have failed, a keen disappointment.

Breast Feeding, How Best Conserved.

Practically nothing has been done to restore universal maternal feeding. To succeed would mean a social and domestic revolution, a universal return to the simple and primitive life like that of our ancestors, who

had large families of children, and nourished them all. It would mean that every girl should follow a simple life from the cradle through a normal early environment, which should continue through adolescence to maturity and motherhood. It means an ideal school life and college life, which now too often seem best calculated to inhibit and destroy the qualities which make strong and vigorous mothers; whereas the school and college ought to contribute much toward fitting our girls for the highest function in the gift of nature.

Our girls seem to be divided into two great classes, one being fitted for social duties alone, and the other being prepared for an earning capacity, whether the individuals will need to use it or not; both are leading strenuous lives and dwarfing the ideal physical woman. Educators and physicians should combine to correct these evils for there must be a remedy.

In seeking a remedy for this state of things, it is not sufficient to study the anatomy and physiology of the human breast. We know that it is a nervous and vascular organ highly organized, composed of acini-form lobules, with lactiferous ducts, and that it is not as capable now of performing its excretory function as formerly: nowadays great layers of adipose tissue bear down upon the glandular fascia. This form of gland, while more in evidence, is not so useful as the tubular mammary gland of a generation ago. It would seem that the organ is now relegated to the realm of art rather than serving nature's purpose for practical utility.

To conserve breast feeding in those who have become mothers, and to encourage normal lactation, means: to conserve nerve force; insure rest and repose in the interim of the nursings; to secure long hours of sleep at night and short day-time periods; to arrange the dress to favor free circulation for the development of the glandular parenchyma of the breast beneath the adipose tissue; to prevent and control digestive disturbances and promote the highest digestive capacity without forced feeding or hurried meals; to eat moderately and masticate thoroughly only simple and wholesome food; to avoid digestive decomposition and consequent auto-intoxication, anæmia and constipation; in short to live a simple and natural life, not shirking the work growing out of the responsibilities of motherhood, but performing these duties so as to avoid fatigue and worry.

The glandular endothelium of the

breast has the property of elaborating milk from the mother's blood after the uterus is emptied. An ample supply of breast milk must be the product of a great functional activity, and such functional force cannot act unless augmented by a vast supply of healthy blood and normal nerve impulse. The numerous vascular ramifications and the nerve supply from both the sympathetic and cerebro-spinal systems serve to connect the mammary gland with the entire circulatory apparatus, and the whole nervous constitution of the woman.

Principles of Infant Feeding.

The principles of infant feeding are fundamental truths taught us by the unerring process of normal maternal feeding, and, if correctly interpreted, are infallible guides applicable alike to all cases of artificial infant feeding. These principles are physiological, chemical, hygienic and psychic, and relate primarily to breast feeding, but are chiefly of practical importance to us in substitute or hand feeding of infants. These principles may be enumerated in the following statements:

1. Milk is the only natural food for the young of all mammals. The milks of mammals have the same general composition, physical properties and nutritive values.

2. The basis upon which the milk of a lower animal may be fitted for the infant, is a proper adjustment of the differences in composition by some synthetic means, which will yield a milk approximating that of the woman; this is called milk modification.

3. All feedings given to infants should be approximately alike in percentages, in order to match uniform digestive secretions. This would also be true when the combined method is employed in using cow's milk and woman's milk alternately. They should be alike in percentages and as near alike as possible in chemical composition.

4. Milk in its natural condition is free from foreign contaminations and practically sterile, and it should be our supreme effort to realize these conditions to infants fed artificially, through clean milk, obtained by dairy hygiene, or milk freed, by non-injurious means, from foreign and dangerous contaminations.

5. Since high temperatures applied to milk are inimical to its food value, so it is unwise to apply heat so excessive as to render inert any of the known or the yet unidentified principles which unite its food elements or augment their value.

6. The thermal death point of micro-

organisms, which invade market milk and which work chemical and fermental changes in it, is fortunately below that point at which known enzymes are destroyed, so that without the slightest injury milk can be rendered innocuous by low temperature sterilization (pasteurization).

7. It is self-evident and should require no argument that any substitute for a normal infant's food should contain nothing foreign to, nor widely different from, the principles found in woman's milk. The elements of both should be isomeric chemically. This principle would exclude unconverted starch, foreign and fermentable sugars, dried dextrine, vegetable fats, beef juice proteids, broths, egg albumin, or globulin, micro-organisms and dirt. It would also exclude nine-tenths of the proprietary infant's foods.

8. Nothing should be combined with an infant's food nor put into its stomach either before or after the ingestion of a meal which will inhibit the normal digestive secretions or render the food indigestible. The wisdom of this principle is shown by the ill-effects of using boric acid in solution for a mouth wash in infants throughout the first year. This practice is general even in breast fed babies and is accompanied by serious digestive disturbances. The rennin, a digestive ferment in the infant's stomach, is designed to clot the milk into calcium paracasein; since this enzyme is not combined with an acid, the soft clot of junket passes into the intestine to be easily digested. The process of normal digestion is defeated by the acid precipitation of the clot into borate of paracasein. This is a tough curd, an insoluble salt of casein and causes trouble in the intestine and undigested curds in the stools. Hydrochloride of paracasein, or the curd produced by gastric juice, is well cared for later in infancy by pepsin in an acid medium. But in infants under eight months it is fatal to success in feeding, to tolerate hyperacidity, either by hydrochloric acid, boric acid, or the malic and citric acid of fruits. Last but not chiefest of evil acids are lactic acid and the fatty acids derived from raw milk in which fermental changes have been allowed to advance.

9. The principle of cleanliness must be applied to every detail of infant feeding, both natural and artificial—the nipples, the mouth, the hands, the clothing, the vessels, the utensils, the water and the surrounding air; in order to avoid or destroy the agents which are inimical to the infant's food. It should be borne in mind that true

cleanliness is intrinsic and must first be in the thought before it can be made effective.

It is also true that the cleanliness most needed in the work of infant feeding is not so much surgical cleanliness as that which may be called domestic cleanliness: the Holland housewife's kind; which forestalls or prevents dirt rather than attempts to sterilize the results of carelessness. To scour and scald is better than to boil if boiling is allowed to replace these more important details of cleansing.

10. Quiet is a prime essential to success in feeding cases, and is so important as to be fundamental. First, quiet in the mother, caretaker or attendant, as shown in their manner and temperament; Second, quiet in the baby itself, its body, its muscles and its nervous system; allowed to lie still most of the time and handled only to adjust its comfort. Third, quiet in the environment; no noise or confusion or loud talking should disturb, frighten or fatigue the baby. Mothers with restless and sick infants need to be quiet, resourceful, strong willed, and self-possessed; not weak of mind or wild with apprehension. Nervous phenomena always react to the hurt of the child who imbibes and is made more restless by this nervous atmosphere.

Methods of Substitute Feeding.

The method employed by the physician in any given case of substitute feeding is very important. It is a sad commentary on our lack of knowledge and skill that so many methods are in vogue, each having its professional defenders. The time is not far distant, however, when irrational methods will be relegated to a credulous public like the nostrum drugs. It seems expedient to define briefly the prevailing methods which will serve as a background to rational ones.

First. The *empirical* method, which has no basis in reason and without knowledge beyond the fact that the food is kept down. This method is often employed with apparent success but disastrous ultimate results, as seen in rachitis and malnutrition.

Second. The *commercial* method, which proceeds from the factory, with its voluminous and gratuitous literature, the syndicate thus forcing our attention, has only the dollar in its eye. Its professional adviser is the chemist who is also commercial and has only one point of view, namely, the cold chemistry of the subject.

Third. The *mechanical* method is a professional method; it is stereotyped and consists of somebody's formula or recommended

mixture carried in the pocket and applied mechanically to every feeding case; it is Dr. X's mixture and therefore, it ought to be good, but signally fails and it is dropped; modified milk is condemned and the baby passes through the ordeal of a new patented food every week until it is beyond recall or traverses the first year and enters the second handicapped for life.

Fourth. The *mathematical* method is based upon correct principles but is employed with the idea that success depends upon nice percentage adjustment only, and the adjacent factors involved are lost sight of. The plan often fails because the mother sees the absurdity of tenths per cent. changes in the food applied to cure vomiting or restlessness, when the remedy lies in better management and care; a baby's digestion should be, and is, flexible, or the normal variation in every breast milk fails to teach us a valuable lesson.

Fifth. The *natural* or *rational* method of substitute feeding is based upon, first, a flexible baby; second, a flexible mixture and a plan which is the product of reasoning with inflexible principles. The first requisite is time to devote to details, a great deal of time is necessary. The physician must guide and instruct the mother or nurse, for judgment is made of experience and this is a medical question. Every case has so many factors that the more difficult the case the more needful it is to individualize it. Hard cases require the combination of the doctor and a good keenly observant nurse and such cases will suggest their own needs which will vary from day to day. Reading books will be helpful if stereotyped methods are not followed. Learn thoroughly milk chemistry, the principles of infant digestion, the principles of milk modification, the principles of care and comfort, and the principles of management.

To determine the actual condition of the infant we must know its capacities, its vital powers, its resistance and its ability to exercise its functions. These are not objective but subjective facts which must be determined. Artificial infant feeding is now so far established upon a scientific basis that it may be affirmed that cow's milk properly modified and fortified with its own elements, in a synthetic mixture, furnishes the best food for our purposes. The full term infant is born with normal capacities but, usually when brought to the physician shows either low function or actual disease, it is sick.

The mixture with which to begin a first

year feeding case must be determined by the condition of the infant as we find it, remembering that every sick infant represents its own blend of low capacities, and the physician must recede from the normal standards to meet them. Then it should be the aim of the physician to advance by a gradual and progressive plan toward the normal standards for that child. It is of vital importance to have fresh and pure materials. The armamentarium of the rational infant feeder during the first year consists of cream, whole milk, under milk, whey, sugar, mineral salts, water and heat. These form a perfect dietetic octave or scale of units with which we can construct as many compatible and nutritious combinations as with an instrumental octave we could develop harmonious musical ones.

Proximate Factors in the Nutrition of Infants.

Bettering the condition of the child who has a birthright to perfect health is one of the highest functions of the physician.

But his duty comprises infinitely more than writing food formulæ or prescriptions or guarding the child from the harmful and retarding effects of disease. To raise the resistance of the child so that it acquires immunity from disease is a better field for his activities than merely to sterilize its environment or to isolate and insulate its mucous membranes. The lines on which this work must be performed will enable the physician to fulfill his highest office, namely; that of a teacher. The child more than the adult needs the application of principles which combine moral, mental and physical training, in order to conserve its best interests for growth and development. To accomplish this we must add a careful consideration of the caretaker, by precept put in her hands exact methods and see that she possesses proper qualifications.

The moral correspondence of the child and its caretaker, will involve in their intercourse the exercise of truth, in word, thought and deed; of kindness, patience, obedience and love.

The mental correspondence of the child and its caretaker will involve in their intercourse the training of the little unfolding mind to recognize and not to fear its surroundings; to know objects and persons and their names; to regulate and conserve the lavish waste of nervous force which the sensitive nervous organization is apt to suffer; to isolate it from much of the mental excitement so common in the surroundings

of a baby and child. To keep the child quiet and away from those who would use it as a toy for the amusement of adults and visitors. To exert a controlling influence over the child by the exercise of a superior will, tempered by kindness and patience; this is essentially a hypnotic influence and is potent for good.

The physical interests of the child involve, first of all, system and order in the routine care; regularity in the habits, in the hours of sleep, of feeding, of bathing and exercise. The selection of suitable rooms for its waking and sleeping hours as regards ventilation, sunshine and quiet. The thoughtfulness and judgment which will insure proper clothing and bed covering to suit the individual, the house temperature or the weather.

The foregoing are all included in the general requirements of management, training and care. These constitute, in my opinion, nine parts of the law in successful work with the infant and child, and they cannot be accomplished without the physician's guidance which requires his devotion to each individual, as well as the exercise of his function as teacher to the mother or caretaker. Part ten of the law, of which nine parts are fulfilled in the management and care, must include all that remains for the development of the full orb'd child.

This is a wide field for the work of the child's doctor and one that requires a large experience with which to mould and fashion good judgment.

SECOND PAPER.

DIGESTION OF FATS, PROTEIDS AND CARBOHYDRATES IN THE FIRST YEAR.

By J. Finley Bell, M. D., Englewood, N. J.

It is assumed that the promoters of this symposium in allotting to me this subject had reference to the fats, proteids and carbohydrates of milk with the various diluents and modifiers usually employed in infantile dietetics. As the ordinarily healthy infant, while being nursed by a healthy mother, with a normal milk supply, rarely has serious digestive troubles, it is further assumed that my remarks are to be directed mainly to the consideration of these constituents as they occur in cow's milk, with the various modifiers and diluents in general use. In so doing I shall constantly refer to

the gross and more or less minute difference existing between human and cow's milk and the various mixtures commonly employed. I shall also occasionally refer to goat's milk for the reason that the author believes that, sooner or later, this tractable,

healthy, economical and cleanly animal, with her more digestive milk, will supplant the cow as a source of milk supply for infant feeding. In the following tables the physical and chemical differences in these milks is set forth.

Physical Differences		Gross Appearance	Reaction	Specific Gravity
Human		Dull, white. In thin layer, bluish.	Alkaline to neutral Litmus indicator. Neutral to Phenothalin indicator.	1.028-1.032
Cow		Opaque, yellowish white.	Neutral to acid in fresh state. Phenothalin indicator	1.028-1.032
Goat		Opaque, chalky white.	Neutral to slightly acid. Phenothalin indicator.	1.032
Chemical Differences (Average)				
Early days of lactation		Human.	Cows.	Goats.
	Fat	2.97%		
	Proteid	2.25%		
	Sugar	6.47%		
	Ash	.30%		
	Water	88.01%		
	Fat	4%	4-5%	4.6-4.8%
	Alb.	Koenig 1.26 Richmond .5	Koenig .53 Richmond .40	Richmond .86 Blyth .62
Proteid	Cas.	1.03 1.00	3.02 3.00	3.49 3.00
Sugar		7%	4.5%	4.22%
Ash		.2%	.75%	.76%
Water		87.30%	87.10%	86.04%

Whey from cow's milk yielded by the Woodruff method, 92 per cent. of albumin, while that from the goat 1 per cent., showing the latter to be richer in albumin, and the goat's whey in turn richer in albumin than cow's. It is a noteworthy fact that most common cows, also Devons and short-horn stock, give milk much richer in whey proteids than is obtained from the Guernsey or Jersey breeds. Of equal interest and importance is the fat chemistry of the various milks as shown by the following tables:

Melting point of milk fats from		
Human.	Goat.	Cow.
36.5+C.	35. C.	38. C.
36.5+	35.5	38.5—
	35.5—	39.5
	34.5	39.5+
	35.5+	40 +
	34.5	40.5
	36.	
	35.5+	
	35.5	

Analysis of the fats of human, goat's and cow's milk, made for me by Dr. S. P. Beebe, of the Loomis Laboratory, is as follows:

	Melting Point	Acid No.	Saponification No.	Iodine No.	Reichert No.
Human	37.5C.				
"	38.	15	195	62	47.+
"	38.				
Goat's	34.33				
"	36.34	3.6	232	45+	43.+
"	35.				
Cow's	39.				
"	40.	8+	228	23+	20.+
"	39.				

Adrianca has shown that the proteids decrease during human lactation, while the sugar increases. A more or less forceful indication that foods other than breast milk should be introduced into the diet of the nursling at a much earlier date than is frequently done. It is well known that there is in human milk a variation in the proteid content within normal limits; and a much greater variation, as regards fats. In cow's milk there is not only wide divergence in the

fat and proteid percentages, but the relative proportions of albumin and casein, composing the proteid, vary greatly in milk from different animals and from time to time in milk from the herd. In addition to the variation in the percentage of fat its melting point and consequent solubility varies according to the apportionment of the principal constituents—palmitin, stearin and olein.

Milk fat, chemically speaking, consists of the esters of stearic, palmitin and oleic acids with minute quantities of esters of other acids, myristic, etc. In addition, milk fat contains glycerides of the volatile fatty acids—caproic, caprylic and butyric, which distinguishes it from all other fats. For instance, fats are solid because of the preponderating presence of stearin and palmitin, while in the soluble or fluid fats there is a paucity of these constituents with olein in excess. Fat may be considered as palmitin and stearin dissolved in olein, and therefore the melting point of fat depends upon the density of this solution. Stearin melts at 55-71 C., Palmitin, 50.5-66 C.; Olein at -5 C. Fat on becoming rancid decomposes into fatty acid and glycerin and the further decomposition of the volatile fatty acids into still lower forms is characterized by foul odors. This can occur in the presence of air and light without the intervention of bacteria.

PHYSIOLOGY OF THE INFANTILE DIGESTION.

The mouth of the infant at birth is dry, owing to the scanty secretion of the saliva, which does not materially increase until the second or third month. The saliva contains an enzyme ptyalin the property of which is to hydrolize starch; that is, convert it into glucose and dextrose. It gradually increases in amount and diastatic power but continues weak until after the sixth month. According to Korowin, the diastatic effect of the saliva of a baby eleven months was found to be as strong as that of an adult. This is due to the imperfect development of the salivary glands at birth, which develop in the following order: the parotid, the submaxillary and lastly the sublingual.

The stomach in the new born is practically a dilatation of the alimentary canal. It is cylindrical in shape, with a capacity of 45 c. c., possesses no fundus and its position is almost vertical. Its musculature is imperfectly developed. The valve-like oesophageal orifice of the adult stomach is wanting in the infant, hence the facility with which fluids are regurgitated. The gastric secretion is fairly well established within the first few days of life. It contains hydrochloric acid with the enzymes pepsin, chymosin and a gastric lipase or steapsin.

The pancreas is more tardy in its development than the salivary glands. The pancreatic juice is alkaline in reaction and contains the enzymes, trypsin, steapsin and amyllopsin. It is believed, but not fully substantiated, that trypsin and steapsin attain their digestive power earlier than amyllopsin.

According to Korowin's experiments, the pancreatic juice does not attain its full starch converting power until the end of the first year of life. Zweifel found that the pancreatic extract digested albumin in the first month.

The liver of the new born is relatively large. At birth 4.2 per cent., the body weight. At six months, 6.1 per cent., one year, 5.8 per cent.; adolescence, 3.8 per cent. and in adults 2.7 per cent. The bile according to Jacobowitsch, is distinguished by its poverty in inorganic salts (except iron salts), cholesterin, lecithin and fat and particularly its small percentage of the special bile acids. The pancreatic digestion of proteids is supposed to be hindered by bile acids, therefore a smaller quantity of bile acid is held to be advantageous at this period of life, because the active ferments of the pancreatic juice are supposed to be less powerful than in older children and adults. But the paucity of bile salts might be considered a hindrance to the assimilation of fat because the fats are emulsified by these salts. At the same time the fat splitting enzyme of the pancreatic juice is given a larger latitude for operation by reason of the less amount of the bile acids. However, we possess so little knowledge of the exact chemical and biological composition of these juices, that we can at most speculate and draw our conclusions from grounds more or less presumptive.

THE DIGESTION OF FAT.

The digestion of fat may be considered as one of hydration, by the enzyme in the stomach, known as gastric lipase or steapsin, and in the intestine by the pancreatic lipase or steapsin. Fat undergoes no change in the mouth. In the stomach it inhibits the secretion of gastric juice, delays the beginning of the gastric secretion and decidedly diminishes its digestive power. According to Pawlow, this inhibition occurs in one of two ways. First, by hindering the secretion directly, in a mechanical way, by coating the gastric mucus membrane and preventing the excitation of the nerve endings. Secondly, indirectly, by reflexly stimulating the nerves of the glands or the inhibitory centers of those nerves. He favored the second hypothesis, but used for these experiments a fat fluid at ordinary temperature. A fat with a higher melting point, partially or entirely insoluble at the body temperature could easily hinder digestion in accordance with one or both the above hypotheses. During some experiments last season with goat's milk in infant feeding,

and while conducting analyses of the various milks, it was found that the melting point of cow's milk fat was much higher than that of goat's milk or human milk, according to the foregoing table. This was further borne out by more extensive analyses of the three fats made for me by Dr. S. P. Beebe, of the Loomis Laboratory, New York, as recorded in the above table.

Oils and fats introduced into the stomach in their plain state scarcely undergo any change, but if introduced in an emulsion the fats are split, and it is worthy of note that the finer the emulsion the more extensive fat splitting takes place. Thus Voldhard found the yolk of egg removed from the stomach after one to four hours was very strongly acid, and split to the extent of 78 per cent. into fatty acid. In the new born this gastric steapsin probably plays a more important part in digestion than has hitherto been considered. As above stated, at birth the fat splitting power of the pancreatic juice is practically nil and not fully established for several months. It has been determined that over acidity of the gastric juice hinders the action of the gastric steapsin, and that large curds of casein in the stomach increase the acid contents of the gastric juice. In both cow's and goat's milk we have, as we shall see later, an albuminoid constituent strikingly different from that in human milk. Cow's casein in the infant's stomach forms hard massive curds, while that from human milk is flocculent and light. Curds of which Dr. Chapin in his book, "Theory and Practice of Infant Feeding," aptly remarks, is intended for a more complicated gastric digestion.

The fat of human milk being a fluid, at body temperature and therefore freely soluble, is acted upon in the stomach by the gastric steapsin and a part split into fatty acid and glycerin. The balance passes into the intestine, where the steapsin of the pancreatic juice, if present, continues the fat splitting, and in the presence of bile, is made freely soluble.

The fat of cow's milk being only partially fluid, and therefore only partially soluble, is acted upon with difficulty by the gastric steapsin, and by reason of its faulty solubility interferes with the gastric secretion. This inadequate secretion is liable to cause an abnormal acid increase, due to the presence of the coarse casein curds. This in turn weakens the digestive power of the gastric steapsin and, coating with insoluble fat the masses of curds already formed, thereby prevents the action of pepsin upon

them. The chyme then passes through to the intestine and comes in contact with bile and undeveloped pancreatic juice with a low fat splitting power, because the enzyme steapsin is not normally active at this period of life. It has been shown that either fluid or solid fat will be more or less readily converted by a mixture of pancreatic juice and bile. Hence, if curds pass through the intestine coated with insoluble fat, it will probably be dissolved and the curds exposed to the trypsin. But it must be remembered that this curd is highly acid, and therefore will require neutralization, and final alkalinity before the trypsin can begin its action. It has been found that a mixture of bile and pancreatic extract will split three and one-half times more fat than pancreatic juice alone, according to Muller. It is now generally believed by physiologists that no neutral fat is absorbed, but all split and brought into a state of solution by the pancreatic steapsin. Pawlow observed that the taking of food containing fat increases the secretion of the pancreatic juice and its steapsin content, and in the same measure its power.

To summarize. The neutral fats of the milk are split by the gastric and pancreatic steapsin into glycerin and fatty acid. Some of these fatty acids probably unite with the alkali of the pancreatic and gastric juices forming soaps. The fatty acids are entirely insoluble in water while the sodium soaps are only slightly so. The bile is the great solvent in this portion of the intestinal tract. It dissolves the lecithin and cholesterol and aids in their secretion. It also acts as a solvent of the free fatty acids entirely and partially so on the soaps. According to Moore, this solvent property is largely due to the bile salts and markedly increased by the simultaneous influence of lecithin.

Hence we have in the first months of life a condition answering the following description: Fat more or less insoluble enters the stomach in combination with an albuminoid, which readily coagulates in large curds causing a gastric hyper-acidity. This in turn interfering with the secretion and fat splitting power of the gastric steapsin. Then passing through the pylorus into the intestine, in a hyper-acid condition requiring extensive neutralization, coming in contact with a pancreatic juice normally weak in its fat splitting power, thereby permitting the fat to pass on and be converted by intestinal bacteria into fatty acids and soaps in an insoluble form long after the bile, which could produce solubility, has been reabsorbed. Also the extensive neutraliza-

tion of the acid contents may produce such a paucity of bile salts as to limit their soluble action on the fatty acids and soaps.

Such is the history of fat digestion as well as fat indigestion and one can readily discern how very important is the question of fat composition and proportion, both in its immediate and remote effects.

PROTEID DIGESTION.

The proteid element of the infant's diet is from a nutritional standpoint the most important. It is the tissue building material of the food supply whereby the marvelous growth of the infant is made possible. A growth that doubles in four months and triples in a year. However, it can only be utilized when sufficient fuel, namely, fats and carbohydrates, are supplied for its metabolism. The proteid elements of cow's milk differ widely from those of human milk. Cow's and goat's milk curds with the addition of an acid, human milk does not. The albumin and casein are practically equal in human milk, while cow's milk has albumin .53 per cent.; casein, 3.02 per cent., according to Koenig; goat's milk has albumin .62 per cent. to casein 3 per cent., according to Blyth. The inorganic salts, according to the following table from Bunge and Hoppe, shows a larger amount of lime in combination with phosphoric acid in cow's than in human milk.

Ash in One Hundred Parts of Milk. (Bunge)		
	Women's	Cows'
Potassium Oxide	.0703	.1720
Sodium Oxide	.0257	.0510
Calcium Oxide	.0343	.1980
Magnesium Oxide	.0065	.0200
Ferric Oxide	.0006	.00035
Phosphoric Acid	.0469	.1820
Chlorine	.0445	.0980
Total	.2288	.72135

In fact casein has been considered by some chemists, an alkali-albumin, and there is certainly a striking similarity. If milk be filtered through a porous cell, casein is left behind, while in the case of alkali-albumin it passes through. But if the alkali-albumin be shaken up with a solution of butter fat, it behaves similarly to milk. However, the polariscope demonstrates a striking difference. Milk proteids are not acted upon in the mouth. In the stomach milk is curdled by the enzyme chymosin, after which the enzyme pepsin in the presence of hydrochloric acid converts the insoluble albumin into soluble and absorbable albuminose and peptone. Milk remains in the infant stomach from 1½ to 2 hours and in case of cow's milk, longer. During this time there is

absorption of peptones, sugar and salts directly into the circulation. (Hoppe).

As we have just observed the action of a mineral acid on the proteid constituent of cow's milk will produce a curdling. Not so with human milk, and here we encounter the first difficulty in the digestion of the proteid of cow's milk. The higher the acidity the more dense and massive the curds. We have previously observed, while discussing the fat problem, that the presence of an insoluble fat retards the secretion and lowers the power and amount of gastric juice. If the amount and power of the juice is lowered the acid coagulation may override the normal rennet coagulation. In the case of human milk this would, of course, be obviated because, not being coagulated by acid, the gastric juice would not be inhibited because the fat of human milk has a much lower melting point; and as there are no large curds produced, because of hyperacidity, the gastric steapsin splits in large measure the fats, thereby, removing them as a hindrance to the digestion of the proteids.

The chyme, composed of curds left undigested by the pepsin, together with peptones and fatty acids and the fats not split by the gastric steapsin, pass through the pylorus into the duodenum where absorption of peptones, etc., is continued. The bile has no action on the albuminoids. However the acid chyme is first neutralized, finally rendered alkaline by the bile salts and pancreatic secretion and immediately the trypsin, which is the peptone forming enzyme of the pancreatic juice, continues the digestion of the proteid in an alkaline medium which was started in the stomach in an acid medium. Other conditions modifying the digestion of proteids were discussed, while considering the digestion of fats. The residue of the digestion of cow's milk is very much larger than with human milk. The quantity of feces in nursing children is normal within rather wide limits, but three grammes to every 100 grammes of milk consumed is a fair average. In most cases fed on modified cow's milk the average will be from three to four grammes.

Heretofore we have dealt with the albumin and casein of cow's milk. In human milk, as we have seen, the albumin and casein are more nearly equal, and since whey cream mixtures of cow's milk have deservedly become popular, and since the only albuminoid content in a properly prepared whey is lac-albumin and a non-important trace of globulin it may be well to consider

what takes place during the digestion of the albumin. That portion which is not encased in the masses of casein is at once subjected to the direct action of the gastric juice, with its acid and pepsin, and readily converted into peptone. While accurate data are wanting it is fair to assume that the digestion of albumin is complete in the stomach under normal conditions, and probably largely absorbed. Quite recently Chapin, of New York, has analyzed cereal gruels of various strengths in order to ascertain their proteid value. The results were quite striking. However, he ventures no data detailing their digestive and nutritional availability. To the very young a vegetable proteid is most foreign, not necessary and possibly harmful.

This seems the proper place for the consideration of the various alkaline substances, such as lime, soda, etc., to milk mixtures, for the purpose of relieving the stomach of part of its proteid digestion, and depending on the pancreatic secretion instead. The gastric secretion during the early months of life is well developed, while the pancreatic is deficient. The futility of side-tracking the stomach digestion under such conditions is at once apparent. About as reasonable as passing Delmonico's and Sherry's to a Sixth avenue restaurant for a first-class dinner.

CARBOHYDRATES.

Milk sugar from cow's and human milks is considered chemically identical. There are some differences however. Cow's milk sugar ferments more readily than human, and crystalizes in wedge shaped plates, while the human crystalizes in rhomboid plates. Much of the milk sugar on the market contains lactic acid as an impurity. Sugar is absorbed in the stomach and intestine, probably aided by the pancreatic juice. All sugars undergo some change. Milk sugar into galactose, cane sugar into dextrose and levulose. Cane sugar is frequently substituted for milk sugar. It ferments readily in delayed gastric digestion with the formation of the organic acids which, as we have seen, interfere with the action of the gastric steapsin, rendering the chyme difficult of neutralization and digestion in the duodenum.

Believing the sugar element of the diet less prone to produce digestive disturbances, and requiring less digestive effort than the proteids, Meigs, of Philadelphia, years ago conceived the idea of modifying milk with cereal gruels or decoctions, intended to mechanically prevent the formation of large

indigestible curds. As we have observed, both the salivary and pancreatic secretions are unavailable for starch digestion until after the 6th or 7th month, and as there are other and more rational methods of limiting curd formation there seems little reason for the employment of cereals for this purpose. More recently certain modifiers have been introduced for the purpose of dextrinizing these gruels. However, when this is accomplished, a simple solution of maltose or dextrose is left, which is entirely devoid of action on the curding process. There seems no possible excuse, either on physiological or practical grounds, for the use of cereal decoctions during the first months of life. In the latter months of the first year, when the salivary and pancreatic ferments, namely, the ptyalin and amylase are fully established, cereals are not only admissible but useful.

CONCLUSIONS.

First.—The discovery of a gastric steapsin is most important, since it explains why infants can take and thrive on a high percentage of fat long before the pancreatic steapsin is fully developed.

Second.—The infantile digestive apparatus is fully equipped at birth for the digestion of the proteids necessary for its growth and development, trypsin being the first enzyme of the pancreatic juice to develop.

Third.—The fat must be fluid and soluble *i. e.* have a low melting point, in order that it may be digested and not disturb the digestion of the proteids.

Fourth.—The milk from many cows, notably the Jersey and Guernsey, has a highly insoluble fat and should not be employed in infantile dietetics.

Fifth.—The limited examination and practical application of goat's milk, with its soluble fat, fits it eminently for infantile feeding, and explains the freedom from both fat and proteid indigestion of infants fed on goat's milk.

Sixth.—The employment of undextrinized cereal gruels during the early months of life is always useless and frequently injurious.

Seventh.—Dextrinized gruels possess no advantage over sugar solutions and hence are unnecessary.

Eighth.—Whey cream mixtures of either cow's or goat's milk, preferably the latter, because of their soluble fat, prevents the formation of large curds by diminishing the amount of casein, substituting therefor a like amount of digestible whey proteid-albumin.

Ninth.—Infants will frequently digest and thrive on simple dilution of goat's milk.

Tenth.—During the latter months of the first year, the child should have cereals, preferably in the form of jelly, and be fed with a spoon. These should include oats, wheat, rice and the various prepared cereals.

THIRD PAPER.

SUITABLE DIET DURING SECOND YEAR.

By Margaret P. Brewster, M. D.,
Grantwood, N. J.

I present this paper with much diffidence, first because of an experience limited to five years of general practice; and second, if challenged, I am not equipped for a debate on the physiology or chemistry of digestion. My only claim to consideration is that until very recently I have been the only physician in a new suburban village made up largely of young parents of sufficient education to realize the importance of proper diet for children.

I have had charge of a fairly large number of first babies from the early months of life to the present time. Only one of my own cases had to be artificially fed from birth. It has been my experience that many babies do not gain weight and strength properly after three or four months, and that among high strung women of the better class the milk fails both in quantity and quality at the sixth or seventh month. In a large portion of cases I advise accessory feeding at this time.

In conjunction with properly modified milk I give cereals, and at eight or nine months vegetables and fruit. My babies are on the following diet by the tenth month, breast feeding being stopped altogether:

First meal, breakfast, 7 A. M., oatmeal jelly, rice, wheat, barley jelly, arrow root, with butter and without sugar, or with milk. Milk to drink after the meal.

Second meal, 10 to 11 o'clock, potatoes, boiled with the skins on and mashed with butter or milk, spinach, young carrots, peas, stringed beans, all mashed fine with very little salt, baked apple, apple sauce and prunes. With this meal no milk. Water is given after the meal is finished.

Third meal, 3 o'clock, bread and milk, oatmeal and milk, or bread and butter and milk. Egg is given with this meal once, and later twice a week.

Fourth meal, 6 to 7 o'clock, cereal and milk and vegetables.

At about the twelfth month raw milk is given. I prohibit, meat, cane sugar, and meat soup, and advise only a little salt be used. To this diet is gradually added raw apples, peaches, pears and grapes, and eggs more frequently, so that by the end of the second year one egg daily is given. Raw fruit is given one hour afterward and not with the meal. By this time the child has three instead of four meals daily.

Children fed on this mixed diet seldom suffer from serious digestive troubles, and they are never constipated. In the correction of the diet of a child previously fed on sweetened and highly seasoned foods, I encounter considerable difficulty. Exclusively milk-fed babies, especially if given from a bottle, do not like to eat solid food. Those who have had sweetened or malted milk do not like vegetables; those who have had meat soups and meat juice will not at first take either cereals or vegetables.

Corrective measures can seldom be instituted gradually and it usually becomes a matter of starving such children to effect the change. My practice is to first impress upon the mother the necessity of following the diet list absolutely, and to order a copy of the list tacked up in the kitchen, and another copy in the child's bed-room. Then I forbid the use of a bottle, night feeding, feeding between meals, or the use of cathartics.

The full diet cannot be given at once. Vegetables and fruit being the last to be digested, I find it often necessary to stop milk entirely for a few days, and give cereals and green vegetables in small quantities. Vegetables are often, "usually in fact" poorly cooked, whereas they need as great care in cooking as choice meats, to make them palatable and wholesome. I believe any child one year of age, not acutely ill, can take properly cooked spinach, carrots, or French peas in small quantities.

If constipation is a prominent symptom, as in my experience it often is, I clean out the lower bowels thoroughly with a warm saline enema, given with a long rectal tube. I advise giving orange juice night and morning at least one hour before or after meals, and olive oil on food if the child will take it; if not given in teaspoonful doses after meals once or twice daily. I order gentle massage of the abdomen, followed by a small cold enema, to be given at a regular hour daily. When the stools are normal in consistency, I omit the enema for one, and

later for two days at a time. A few days of this regimen almost always overcomes the troublesome and often serious symptoms of improper feeding. Attention to the details of this plan has brought to me almost uniformly successful results, and I am sure in the experience of every physician there is nothing more gratifying than good results with the commendation of the patient.

I append another diet list that I have used in the second year:

Breakfast: Hominy, cream of wheat or strained oatmeal, with cream or milk, but no sugar, bread and butter, baked potato, mashed, with salt and butter. Milk to drink after eating.

Dinner: Every day an egg. Rice, hominy, baked potato, spaghetti. With every dinner have cereal as vegetable.

Supper: Corn meal, rice, hominy, cream of wheat or strained oatmeal, baked potato, bread and milk or milk and butter. Milk after eating. As dessert, fresh raw fruit.

FOURTH PAPER.

SECOND YEAR DISORDERS OF INFANTILE DIGESTION.

By Alexander McAlister, M. D.,
Camden, N. J.

An ancient medical text-book ingeniously arranges all human diseases in one of three comprehensive groups, namely, diseases of the head, diseases above the diaphragm and diseases below the diaphragm. How certain diseases could be kept from riding the fence and others from roaming at large is quite beyond the powers of modern conception. But it is interesting to note that the originality of this anatomical classification won for its author great celebrity.

Upon first thought a chronological division of the disorders of infantile digestion would appear to be of this ancient type, if not, indeed, evidence of disease of the head. However, a deeper study of the subject serves to dispel this conception as erroneous, although, strange to say, none of our great writers on pediatrics ever thought to differentiate second year disorders of digestion from those of the initial year. That such a distinction can be clearly made and considered with profit on such an occasion as that which has called us together, the writer sincerely trusts these remarks and the subsequent discussion may adequately demonstrate.

It will not matter for our present purpose that infantile digestion during the second year, normal and abnormal, does not differ materially or essentially from that of the latter part of the first year. Distinction without any difference is quite sufficient. The second, or final year of infant life, is pointedly summed up by the laity in the significant term "the second summer." In their estimation it is the severest ordeal of infant life. The second summer successfully passed, they would argue, gives the infant a good lease of life for the period of childhood.

The number of infants having disorders of digestion per thousand grows smaller for any particular month as the second year is reached and entered upon for several obvious reasons. The frailest have dropped out of the race while the strongest ones are no longer to be classed as of weak digestive power. Disorders of the first year, which have been survived but not removed, are carried over into the second year, all else being equal, in a milder and more amenable form. Barring the intervention of serious complications the mere increment of time tends toward milder form and total cure of such disorders. An analysis of a group of cases of second-summer disorders must consider—(1) those which have been carried over from the first year, and (2) those which are incidental to the second year. Two types of the former are well-known to every observer. First we have the puny enigmas of life, which have been fairly well solved. Delicately born and delicately fed, they have lived to face the final ordeal of infancy, the second summer.

We next note infants subject to repeated attacks of acute or sub-acute indigestion. They are apparently stronger than the former, yet have small withstanding powers. Probably one or two intercurrent maladies of childhood or the lurkings of a constitutional disease are accountable for this morbidity of the digestive function. But whether this or imprudence in feeding the result is that the second summer finds such infants with more or less functional, if not organic, disease of the digestive apparatus. Such are more difficult to manage and less likely to survive the dangers of this period than infants delicately born and nurtured. Another type is found in cases complicated by the development of one of the food diseases, namely, scurvy and rickets. These are nearly always carried over cases and not infrequently date from as early as the sixth month. The demand in these for special

treatment of the constitutional disease and the vicious tendencies in the digestion and assimilation of food which characterize such cases, make them difficult to manage during the summer months.

In the production of disorders of digestion that in origin are peculiar to the second year advancing age and weaning are important causes. They act separately and conjointly in producing and promoting disordered digestion. Mothers and nurses as a rule feed too richly. They are dominated by the false notion that what an infant needs above all else is strong food. Acting upon this half truth infants in their second year are especially prone to be over-fed. The food may be whole milk of rich quality when at least a quarter should be thin gruel in order to aid in the digestion of the stiff cow curd. Weaning is much too frequently treated as if practically synonymous with promiscuous table diet. The little life is often almost precipitately cut loose from all system and maternal concern, if not from common sense. In a flagrant instance the writer recently observed an infant was given a few inches of "half smokes" in less than a week after weaning. "The fellow cried for them and what else could be done," the mother weakly pleaded.

Most frequently the error lies in allowing too much starchy food, especially potatoes and oatmeal, not for the age but for the digestion of the child. The result is chronic indigestion with its train of ailments. Features characteristic of the second year of infancy, and which frequently result in disturbances of digestion, are the ability of the infant to move about and its proneness to swallow everything that can be put into the mouth. To these may be added its proclivity for clamoring for anything that pleases the palate and the grosser disturbances incidental to dentition. In questions of diagnosis and treatment, the family physician must take these features into consideration if he would be successful. He cannot afford to accept the mother's word as to what the child has not eaten. Her ignorance of the facts and the mother instinct are always sufficient reasons for her negative reply. He should always give the child the benefit of a doubt; and ipecac, or other convenient emetic, will frequently bring interesting facts to light.

For the sake of argument, a case may be cited. A child in one of our crowded courts had violent acute disorder of digestion. The physician, after carefully scrutinizing the patient, confidently asserted it had eaten

green pea-pods. The mother stoutly denied it, pleading that peas had just come in the market, that they could not afford them and had none in the house since the previous summer. The doctor insisted that pea-pods were the cause and gave an emetic. The pea-pods were largely in evidence when the child re-asserted itself. With uplifted hands the mother exclaimed: "Well! of course, a *good* doctor, what don't he know!" The court easily agreed and from that day consulted only the *good* doctor. The doctor had recognized in his patient the child he had seen in a near-by alley squatting by a slop box regaling itself with tempting pea-pods.

The popular notion that some infants have an inborn dislike for milk is an error. The distaste is imaginary or acquired and belongs to a period later in life. Infants clamor for other food only because it pleases their palates better. Many need little encouragement in order to show an early preference for solid and semi-solid food.

Mothers need to be educated to judge of a child's needs apart from its greed. They should know the importance of making milk the basis of practically every meal to the end of the second year. They need to be strongly impressed with the fact that disorders of digestion are vastly more easy of prevention than of cure; and finally, that frequent and abrupt changes in the food are disastrous to the functions of digestion. In the treatment of digestive disturbances all food, excepting milk and later also orange juice and beef broth, must be denied. The milk should be largely diluted with thin gruel and given at prolonged intervals. Virtually the child is put on first-year diet. Water should be given systematically and in liberal quantities. While the alimentary canal is being cleared of all irritating matter and specially treated the case may demand the use of thin gruel and cooling drinks to the exclusion of milk.

When systematic feeding is resumed it should be with food suited to a child several months younger and the strength of the milk gradually increased as the completeness of digestion and the appetite may warrant. It is in these cases that peptonized milk or peptogenic powders are of marked temporary value. Return to farinaceous food must be deferred until the digestion is fully normal, then the change should be made gradually. Some prefer to resume the partially starchy diet by the aid of diastase administered after each feeding. Chronic indigestion indicates a continually operating

cause. The remedy lies in denying farinaceous foods and returning to first-year diet.

The concluding Paper of the Symposium on Nutrition, by Dr. A. A. Strasser, on "The Etiology of Rachitis, Scorbutus and Cretinism," and Dr. I. H. Hance's Paper on "Diarrhoea in Infancy and Early Life," with the Discussions, will appear in the September JOURNAL.

Correspondence.

Elizabeth, N. J., July 7, 1906.

To the Editor of the Journal:

Sir.—The issue of the JOURNAL for July, 1906, contains a clinical report, entitled, "How I Successfully Treated a Case of Appendicitis."

This subject is one of great interest to the profession and has proved an ever-fruitleful topic for discussion. The average practitioner relies for much of his reading information upon the experience of others as set forth in clinical reports in our medical journals. It would seem, therefore, imperative that such reports be characterized by scientific terminology, complete data and details as to the rationale of treatment, particularly where such treatment constitutes somewhat of an innovation.

From the standpoint of a seeker after knowledge I would ask the writer kindly to elucidate certain portions of the report which appear to me to be obscure.

It is stated in the report, "The theory under which I worked in treating the appendicitis was *positive rest to the location affected*." I would ask in what way the administration of calomel, castor oil and turpentine as cathartics contributed toward this end?

To quote again from the report: "A part of my plan was, if I found it necessary (if the local inflammation continued), was by an 18-inch soft rectal tube to slowly inject once daily or twice, or even more times if thought prudent, a saturated solution of boric acid as an antiseptic."

Assuming that the antiseptic injection was designed to reach the site of inflammation, will the doctor not explain to us the technique of this procedure—the position of the patient during the injection, the quantity used, and by what means he was able to satisfy himself that the injection had reached the caecum? Also whether the accepted pathology of appendicitis warrants the assumption that the inflammatory process could be favorably influenced by injections given per rectum? Possibly though, I assume a wrong construction of the phrase "as an antiseptic." Its ambiguity, however, leaves one in some doubt as to its meaning.

The doctor states that he "had the bowels smeared frequently with a combination of equal parts of menthol powder, gum camphor and hydrated chloral, to assist in removing the local soreness." There is no mention of a laparotomy incision; the mixture was presumably not given by mouth; is then, the term "bowels" employed in a sort of generic sense intended to broadly include the skin of the abdominal wall?

The report speaks of an X-ray photograph of the abdominal cavity, showing that the appendix had been inflamed. It would certainly be of benefit to have it explained in just what way, aside from the presence of a circumscribed abscess, the radiograph brings out evidence of ap-

pendicular inflammation. The coëxistence of an appendicitis and a right-sided renal calculus would seem to be of sufficient rarity to afford unusual opportunities for differential diagnosis. I believe that many of us would appreciate a statement of the cardinal points of differentiation which served to establish the independent though practically coincident appearance of the two conditions.

Will not the doctor in a future report give us a more detailed account of this interesting case?

Very truly yours,

FREDERICK H. PIERSON, M. S., M. D.

COLABORATORS' NOTES.

Mercer Co. C. H. Mitchell, M. D., Reporter.

At a special meeting of the Mercer County Medical Society, held July 2d, action was taken regarding the interference and financial injuring suffered by the general practitioner as a result of the P. R. R. surgeon or physician being called upon by his employers to attend all persons injured or taken sick while doing service or traveling upon any of the roads or properties controlled by the Pennsylvania railroad. This, in the opinion of the Mercer County members, is undoubtedly an injustice to the general practitioner, as he is compelled in many cases to stand aside and witness the rendering of free service to some of his best and oldest patients, who would probably have secured his services if the P. R. R. did not force a physician upon them with the statement that the medical attendance would be absolutely free.

Probably by the united efforts of various county societies sufficient pressure could be brought to bear upon the P. R. R. officials to have this mode of practice changed so that their physician would be instructed to attend the patient at the time of the injury only, and during the visit secure such data as he may require and then have a regular practicing physician called upon to attend the case.

The Mercer County Medical Society has for the past two years been making a strenuous fight against all forms of contract practice and they feel that a corporation physician is one of the worst forms in existence, as he is rendering unlimited medical aid, for practically nothing, to those who are in the best of condition to pay fair prices, even receiving it cheaper than the poorest man, and all this at the expense of the physician.

An innovation in hospital practice has been established by Dr. F. V. Cantwell, at St. Francis Hospital, Trenton. His system causes the retirement every three years of the senior surgeons and physicians and the advancement of their assistants. This plan of Dr. Cantwell's is greatly appreciated by the younger men, as it gives them opportunities for promotion that they rarely had before.

"Patent Medicines."—Under a new law of Minnesota a State medical board has been constituted with directions to procure samples of all the "patent medicines" sold in the State, subject them to careful analyses and publish the same in a weekly bulletin to be issued by the department. If the preparations contain opiates, alcohol or other deleterious substances, that fact, with the quantity, will be published.

THE JOURNAL

OF THE

Medical Society of New Jersey.

AUGUST, 1906.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any one failing to get the paper promptly will confer a favor upon the Publication Committee by notifying them of the fact.

All communications relating to the JOURNAL should be addressed to the Committee on Publication, 95 Essex avenue, Orange, N. J.

THE PUBLICATION COMMITTEE AND THE JOURNAL.

In undertaking the conduct and management of the *Journal* for another year, the Committee on Publication desires to extend its thanks to those who, by their contributions of news items, papers, &c., have assisted in making the *Journal* a welcome visitor to the medical men of this state.

The committee is held responsible by the trustees for the management of the *Journal*. It selects, reviews and, with the assistance of the editor, revises all papers, communications, &c. While the society is not responsible for the opinions expressed by the writers of papers, still the committee seeks to eliminate all utterances of a personal, political or objectionable character. The pages of many medical journals are disgracefully marred by the display of nostrums in their advertising columns. We know that the members of our society would, if necessary, dispense with advertisements altogether and pay the whole cost of publication rather than stultify our teachings and tarnish our good name for the sake of a few paltry dollars.

We have sought to present a CLEAN JOURNAL, which shall be acceptable to all and offensive to none. A state society journal should never be an instrument for personal exploitation nor under the control of any individual, but should be the mouth-piece of the *whole society*. At a largely attended meeting of the board of trustees it was decided to make a change in the editor-

ship. Dr. David C. English, of New Brunswick, who is well known to the medical profession of this state as a man of ability and literary taste, was unanimously elected as editor for the coming year. He has signified his willingness to undertake this work and we bespeak for him the cordial support of all the members of the Society.

WILLIAM J. CHANDLER,
CHARLES J. KIPP,
EDWARD J. ILL,
Committee on Publication.

The Editor, His Relation to the Journal And the Members of the Society.

The Board of Trustees, in whose hands is the control of the JOURNAL, unexpectedly to me and against my judgment, elected me editor of this JOURNAL for the ensuing year. This honor is very highly esteemed, but realizing that the position is one of great responsibility, it was accepted only after careful deliberation. The assurance of the hearty coöperation of the Trustees, Publication Committee and Reporters of the county societies largely determined my decision. The general appearance and character of the JOURNAL will be the same as under my predecessor whose earnest work we recognize and for which he received the merited thanks of the Board of Trustees.

In assuming charge we desire to emphasize two facts: First—That the JOURNAL is not to be the exponent of the editor's dogmatic beliefs or judgments. The editorials will be few in number and we trust will never trespass upon the readers' patience, or touch upon controverted questions in a manner calculated to call forth merited condemnation. Second—The JOURNAL belongs to the members of the Society. They support it and are responsible for its character and its worth to the profession, and through it for the maintenance of the high and honorable standing of the Medical Society of New Jersey. Each individual member we hope will feel it incumbent on himself, or herself, to help make it more successful and influential by contributing to its columns any facts that tend to advance the sciences

of our profession or their practical application, or any notes, reports or information that may be of interest or profit to the profession.

We shall always welcome kindly criticism or suggestions calculated to make the JOURNAL more helpful to our members and more worthy the Society it represents.

DAVID C. ENGLISH, Editor.

New Brunswick, N. J., July 5, 1906.

OUR JOURNAL TO LIVE AND TO GROW.

The JOURNAL has entered upon the third year of its existence. We believe it has proved its right to live, as its past record has given evidence of increasing life and vigor, and its future is bright with hope of a sturdy growth. The success of the past is largely due to the growing belief that the annual volume of "Transactions" failed to meet the wants of our members and that a monthly journal would bring the membership into closer relations, as it would provide a medium of communication which would tend to arouse the *esprit de corps* of the profession, stimulate scientific investigation and improve the interest in, attendance upon and work of our State and county medical societies.

The wisdom of the change must be apparent to all, when we consider the increasing number and value of the scientific papers and addresses at the last two annual meetings of the State Society not only, but also the many read before the county and other medical societies and also the communications, medical news items from the various parts of our State and the outside world that have been published in our JOURNAL. Also the great assistance it has given and is capable of rendering, in raising the standard of medical education, advancing the profession in scientific knowledge and its practical application, and in protecting the public against avoidable disease and quackery. As to its value in the last-named good work we need only cite the JOURNAL's practical and efficient help rendered our Committee on Legislation in their excellent work in ad-

vocacy of pure foods and opposition to osteopathy and the nostrum evil.

The Publication Committee and the editor have sought by faithful and earnest work on the JOURNAL to serve the Society in the endeavor to accomplish these worthy aims. The many expressions of approval by members at the recent annual meeting and the Society's unanimous vote of thanks will tend to encourage those in charge in their endeavor to improve the JOURNAL.

Our hope for the future of the JOURNAL rests upon these expressions and the belief that the members of our county societies generally appreciate its worth and have begun to realize that it devolves upon them to make the JOURNAL worthy of the oldest medical society in the country with a record of work and accomplishment second to none.

IMPORTANT NOTICES.

Special attention is called to the notice on page iii of advertisements headed "Preserve Your Journals." This is an excellent opportunity to have the year's issues bound at reasonable prices. Members desiring to avail themselves of these rates should apply promptly to the Publication Committee, 95 Essex avenue, Orange, N. J.

Special attention is also called to the Supplement issued with this number of the *Journal*, containing the official list of officers, committees and members, and close scrutiny of names and addresses is urged. Members discovering any errors will please report the same, with corrections, promptly, to the Publication Committee, Orange, N. J., as the utmost accuracy is desired in the alphabetical list of members which will be issued in the supplement to the September number of the *Journal*, which goes to press August 20th. Secretaries of the County Societies may add names of new members received by their respective societies provided the annual dues for 1906-7, are sent with each new name. All new members so reported will receive the *Journal* regularly. Please note the change in the address of the Committee on Publication from Newark to 95 Essex avenue, Orange, N. J.

GARBAGE AND SEWAGE DISPOSAL.

While the questions of proper methods for the disposal of the garbage and sewage of our cities and towns are problems for the civil engineers to solve, the people have the right to insist that they shall be solved in ways that will not jeopardize the healthfulness of our communities and the lives of our citizens, and so far as possible, will prevent the strong putrid odors caused by the decomposition of organic matter. Therefore the physicians and health officers have a duty to perform, being the most competent to decide as to the danger to health and life, and the competent engineer, appreciating the question of danger, will ever recognize that fact.

We certainly have a right to insist that our communities shall not suffer from the methods adopted by our neighbors whether those neighbors be an adjoining town, county or state, and they have the same right of protection from our faulty methods that affect injuriously their health interests. Our attention is called to this subject by an account on another page of the *Journal* of the recent defilement of the bathing beaches of our sea coast by the garbage from New York City. We commend the promptness in action of our State Board of Health, and also the prompt acknowledgment of guilt (of subordinates, the authorities not consciously offending), and the prompt correction of the evil.

The question of garbage disposal has been a difficult one to solve, and in fact has not yet been solved to the perfect satisfaction of our engineers and municipal authorities. Still more difficult of solution is that of sewage disposal, especially of our large cities or districts. The most serious case that has taxed the skill of engineers and health authorities, has been that of the Passaic Valley, requiring a system of sewage disposal that shall meet the needs of a population of 1,500,000 people. The New Jersey State Sewerage Commission, after long and careful consideration, proposed a plan which has aroused much discussion pro and con, but the general consensus of opinion

seems to be that the method recommended is economically and scientifically adapted to the ends desired. Briefly stated, it proposes to carry all the sewage of this large district—covering a distance of about twenty-six and a half miles (from the Great Falls at Paterson to New York bay), to a point in New York bay, in the center of the channel and discharge it at least forty feet below the surface, through a trunk sewer, or intercepting sewer, which shall receive the sewage, freed so far as possible from ground water and rain water, of the several cities and towns along the route.

One of the ablest civil engineers—the late J. J. R. Croes, of New York, a Jerseyman by the way, in an able paper read before the N. J. Sanitary Association, in discussing this plan said:

“The discharge of the entire New Jersey Sewage into this strong and large tidal current would be less liable to produce unwholesome conditions along the shores of New Jersey, New York and Staten Island than would be the discharge of the same matter in Newark bay and the Kills. Such a method of disposal is very different from the discharge of sewage into the surface of land-locked bays fed largely by the surface waters from the adjacent uplands. From such bays sewage should be excluded entirely.”

It is a great satisfaction to know that those in charge have been so painstaking and thorough in safeguarding the health interests of our state, and it is gratifying to our state pride to know that New Jersey, in caring zealously for its own citizens is considerate in her efforts to guard our sister state of New York from any danger that might arise from faulty methods adopted for the safety and comfort of the inhabitants of our own commonwealth.

OUR COLABORATORS.

We desire to call special attention to the action of the State Society constituting the Reporters of the various County Medical Societies collaborators with the editor. It is exceedingly practical and and helpful and we welcome their aid and earnestly solicit their hearty response to the Society's call. We desire full reports of the County Societies' meetings, with copies of papers read which are of special interest, and reports of interesting cases. Our limited space, with

our earnest desire to hear from *all*, may compel selection for early publication of papers which are brief, most seasonable and practical, or necessitate abridgement of lengthy papers.

We also request prompt notification of all deaths of physicians in their respective counties with concise obituary sketches. It is suggested that members of county societies aid their Reporters in securing such matter. We give credit to Dr. C. H. Mitchell, of Mercer county, as the first Reporter to respond.

THE PURE FOOD BILL.

It is doubtful if any Act passed by Congress during its last session is more important in its far-reaching results, if properly enforced, than the one entitled—

"An Act preventing the manufacture, sale or transportation of adulterated or misbranded or poisonous or deleterious foods, drugs, medicines and liquors, and for regulating the foods, drugs, medicines and liquors, and for regulating traffic therein, and for other purposes."

This Act is properly known as the Pure Food Bill. There is nothing more essential in the preservation of the health of our citizens and the development of strong bodies capable of meeting the requirements of this strenuous age, than a pure wholesome food supply. It is therefore a cause for great rejoicing and thanksgiving that Congress has passed the National Pure Food Bill by the unexpectedly large and decisive vote of 64 to 4 in the Senate and 242 to 17 in the House, in spite of the powerful and determined efforts of its enemies to defeat it. This overwhelming majority is due to the fact that public sentiment had been aroused by recent revelations of the extensive adulteration of our food supply and of the contamination of food through the unsanitary and in many cases filthy conditions existing where the food is prepared and packed. And here we may say that to the very effective work done by the medical profession is very largely due the credit of this great victory.

The Journal of the American Medical Association has an excellent editorial on this subject in the July 14th issue; we give its closing paragraph, as follows:

"While giving credit to the few faithful members of the Senate and the House who year after year patiently worked for the measure, such as Senator Heyburn and Congressman Hepburn and Congressman Mann toward the last (for his final presentation of the case with the well-worked-out

cases of physicians who have held prominent positions in professional, civic or re-'object lessons' was the most effective argument on the subject ever presented), there were certain forces outside of Congress which had much to do with its passage. Undoubtedly the strongest and most effective of these was the medical profession. Naturally, no class of people know as well as physicians the harmfulness, the wide prevalence and the varied character of frauds in food stuffs, and naturally, therefore, they were the ones to take the lead in the movement for the suppression of these frauds. And the American Medical Association, acting for the medical profession, through its committee on medical legislation, with its far-reaching state and county auxiliaries, made it possible for physicians all over the country to act in unison, and consequently with effect."

But though this great victory has been won, and will stand, it is only the first step. Congress must make the necessary appropriations and the heads of departments charged with the execution of the law must make adequate regulation for its enforcement. This will doubtless be done before the time specified for the Act to take effect—January 1, 1907—and then *it must be honestly and rigorously enforced*.

The appointment by President Marcy of our State Society, of Dr. Edward J. Ill. of Newark, to fill the vacancy on the Committee of Publication, occasioned by the resignation of Dr. English, is most acceptable to the other members of the committee, the editor, and, we believe, to every member of our society.

The members of our society will regret to hear that Dr. E. L. B. Godfrey, at the annual meeting of the State Board of Medical Examiners, held July 5, was compelled to decline re-election as secretary of the board because of impaired health, his recovery from an operation for appendicitis, though steady, has been very slow. Dr. Godfrey has served as secretary and executive officer of this board about eleven years, and to his fidelity and efficiency is largely due the high standing of the board which, we believe, is at least equal to any in the country. This standing is due to its strictness in demanding that no one shall be admitted to the ranks of the profession unless educationally qualified, and because of which New York has recently indorsed the certificate of med-

ical license of this state, in lieu of an examination—the only state medical license thus recognized by New York. Fifteen other states have endorsed New Jersey's medical licenses.

The secretary of the medical staff of each hospital located in the state is kindly requested to send to the editor of this *Journal* a list of the members of the staff, full names, clearly written. Brief notes of important cases and reports of major operations performed will be thankfully received. We believe the *Journal* should more fully set forth the work of the medical profession in New Jersey.

The State Medical Societies are gradually becoming convinced of the wisdom of publishing a monthly *Journal*. At the annual meeting of the Arkansas Medical Society, in May, 1906, it was decided to change the monthly bulletin into a monthly *Journal*, and to discontinue the publication of the annual volume of proceedings. Hereafter all the society's transactions will be published in their *Journal*.

It is gratifying and encouraging to know that our work is commended not only by our own members but also by our sister societies and by those who have held prominent positions in medical and other scientific circles. E. g. the following:

"The New Hampshire Medical Society acknowledges with thanks the receipt of a copy of the *Journal of the Medical Society of New Jersey*. You have my best wishes in the excellent work you are bringing out to the members of your Society.

GRANVILLE P. CONN,
CONCORD, N. H."

Dr. Conn, after thirty-seven years of faithful and efficient service as Secretary of the New Hampshire State Medical Society, has resigned. The memory and influence of his work in that Society and of his services to the profession at large, and for the good of the people especially in the cause of public health through the American Public Health Association, will abide. We appreciate and reciprocate his kind wishes.

Prizes for Research on Sleeping Sickness.—The King of Belgium, as sovereign of the Congo Free State, has appropriated \$50,000 to be awarded as a prize to the person who discovers a remedy for sleeping sickness. Competition is open to all nationalities. In addition, about \$16,000 will be given as a special grant to further research on the prophylaxis and treatment of the disease.—*Journal Amer. Med. Ass'n*.

Clinical Department.

TRAUMATIC CEREBRO-SPINAL MENINGITIS.

By William H. Shipps, Bordentown, N. J.

Case 1.—On January 15, 1906, the writer was called in consultation to a case that presented the following history: On January 13, M. C., aged 51 years, a married farm-hand, well nourished, of vigorous physique, while felling trees in the woods near his home, sustained a compound fracture of the lower third of the left leg, the result of contact with a falling tree; no other injuries were apparent. The patient lay upon the ground, exposed to the cold and damp, for nearly an hour before help came, when he was removed to the house and his family physician summoned. On the arrival of the doctor, he complained of slight chilliness of temporary duration. The fracture was reduced and the patient left in a comparatively comfortable condition. The following morning he was again visited by his physician, who found him bright and cheerful, but with a slight cough and congestion of lower portion of right lung; temperature 101.2, respiration 24 per minute, kidneys and bowels normal. Later in the day the doctor was hurriedly called to the patient and found him in a profuse perspiration, marked dyspnoea, eyes rolled back in head, pupils dilated, whole body in a state of rigidity, opisthotonos well marked, no vomiting, Palmar reflexes present, Kernig's sign present. This condition continued for fifteen hours, during which time the patient was conscious and able to take nourishment. Later he fell into a state of coma followed by complete muscular relaxation, in which condition he was found when visited by the writer and from which he never aroused, death ensuing January 17th, or four days following the accident.

Case 2.—On April 30, 1906, Arthur C., aged 8 years, of good physique, fell from a tree into a shallow creek. Just what part of the body was struck when he fell could not be ascertained, as there was no visible mark of injury apparent, and only slight muscular soreness that attracted but little attention. There was nothing indicating any serious consequences until the expiration of thirty-six hours, when muscular twitchings of the upper and lower extremities were noticed. The day following muscular rigidity of the entire body developed with marked retraction of the neck muscles. This condition continued for four days, when I was called to see the patient and found him lying upon his back, legs and arms extended. Opisthotonos well marked, pupils dilated and slight paralysis of the muscles of the left side of face, with ptosis of left upper eyelid; temperature 97.4, pulse 90, respiration 20. Examination of the abdomen showed decided tympanitis, a slight herpetic eruption that later spread over the entire abdomen and chest. Patient showed hyperesthesia and mental irritability when touched, or spoken to. Mind was perfectly clear and articulation normal. The day following there was a slight rise in temperature, but at no time did it exceed 101°. On the tenth day following the accident, the patient suddenly fell into a state of unconsciousness with entire muscular relaxation, death occurring a few hours later. These two cases mentioned are interesting because they presented most of the symptoms noted in the ordinary forms of cerebro-spinal meningitis, and the fact that both developed as a result of traumatism, and, therefore, could not be classed with the infectious form of the disease.

PERSISTENT HICCUGHS.

—R. M., 40 years of age, had just recovered from a severe attack of typhoid fever, when, without warning an attack of hiccoughs developed that persisted, with but slight intermission, for six days, during which time the condition of the patient was most critical. After the free use of the recognized remedies, the writer began the hypodermic use of strychnia nitrate, in combination with morphia sulphate and atropia, giving grain 1-50 of the first named, $\frac{1}{3}$ of the second, and 1-150 of the last named drug every four hours, alternating with a solution containing tinct. gel-seminum and spirits of chloroform. Relief from the symptom was manifest in a short time, and in twenty-four hours recovery was complete, with no return of the trouble. Of course relief might have followed other and simpler treatment, but my impression is that the nitrate of strychnia is the remedy that exerted the most pronounced curative action.

SIMPLE CARDIAC EDEMA.

J. A., aged sixty-one years, was admitted into the Salford Royal Hospital on May 8, 1903, with extensive edema all over the body; the surface was cold and cyanosed. The heart was dilated, and the pulse was quick and feeble with intermissions. A faint systolic murmur was heard over the mitral and tricuspid areas. Basic hypostatic congestion existed at the posterior third of both lungs, and the liver projected about a finger's breadth below the costal margin; but there was no ascites. The tongue was thickly coated, and the temperature was subnormal. For a week or two before admission the patient passed very little urine. During this time he had got out of bed at intervals, and had gone downstairs to sit by the fire. On admission the patient was put to bed, and was given a little stomachic medicine, but no diuretics, cardetics, cardiac tonics, nor alcoholic stimulants. On the day after admission he passed only nine ounces of urine. It was high-colored, clear, acid; specific gravity, 1024; it was free from albumin; it contained 3.1 per cent. of urea, but only 4.6 grams of sodium chloride. On the second day he passed 31 ounces, on the third 60, on the fourth 63, on the fifth 109, on the sixth 163, on the seventh 220, and on the eighth 214. A considerable portion of the accumulated fluid having now come away, the daily amount of urine dropped to from 60 to 70 ounces a day. When the volume of urine was at its highest the urea only reached 0.25 per cent. The percentage of urea slowly increased; on the tenth day it was 0.6 per cent., and on the twelfth day it rose to 1.3 per cent., and subsequently to 2 per cent. The daily amount of sodium chloride increased with the output of urine; when the urine reached 220 ounces, the sodium chloride amounted to 22.7 grams. It remained above 18 grams until the twelfth day, when it dropped to 14.5, and then it settled down to about 12 grams, the daily volume of urine being from 45 to 55 ounces. After one month's stay in hospital, the patient was discharged free from dropsy and with restored cardiac compensation, due solely to physiological rest.—*J. Dixon Mann, M. D., F. R. C. P., in British Med. Jour.*

(In failure of cardiac compensation the doctor says rest alone is insufficient to restore it in many cases, and where medicinal remedies are needed recommends digitalis, believes it superior to strophanthus. The judicious use of alcohol is sometimes of great efficacy in tiding the heart over a

critical period; but when the kidneys are diseased it is to be avoided unless it is absolutely necessary. "Physiological rest comprises absence of all avoidable calls, mental as well as physical, on the cardiac energy, so that it shall be solely devoted to the nutrition of passive tissues and to the transmission of adequate blood-pressure to the secretory organs. * * * Low blood-pressure not only limits the output of water, but it also determines retention of sodium chloride, which probably constitutes an important factor in the production of the edema.")

News from Current Literature.

Physique and Tuberculosis.—Dr. W. C. Rivers advances the following reasons in favor of the view that an hereditary causal relation to pulmonary tuberculosis may be predicated of mouth breathing and deficient physique: 1. That both conditions prevailed to a much greater extent among consumptive males, quite independently of their disease, than among a comparable series of non-tuberculous men. 2. That whereas some causes of mouth breathing, as also physical build, are known to be hereditary, a family history of phthisis is much more often given by those who are mouth breathers or of deficient physique—whether they be healthy or phthisical—than by others. 3. That the physique incidence of mouth breathing in phthisical subjects probably differs from that in the non-tuberculous. 4. That consumptives of a naturally good height weight ratio fall ill, on an average, at a later age than do others.—*British Med. Journal.*

Retrobulbar Optic Neuritis Following Childbirth.—Dr. C. J. Kipp reports a case of recurrent retrobulbar optic neuritis of one eye following childbirth, and ending in atrophy of the optic nerve, with whitening of part of the eyelashes and eyebrow of the same side, the eye becoming totally blind. The author thinks it most probable that the pregnancy caused a disturbance of the vascular supply, a congestion at or near the apex of the orbit, and that this produced pressure on the optic nerve and its sheaths, and also on the branches of the ophthalmic branch of the fifth nerve. The case seems to be the only one in which the whitening of the eyebrows and lashes has been observed in connection with retrobulbar optic neuritis; only a part of the lashes and of the hair of the brow were affected, namely, those in line with the course of the supraorbital nerve. The author reports a second case of retrobulbar optic neuritis of one eye, following childbirth, with recovery of vision.—*Journal A. M. A. through N. Y. Journal.*

A Case of Glycosuria Following the Administration of Mercury.—The author has noticed a case of glycosuria caused by the use of a mercurial preparation (nucleinate of mercury) administered subcutaneously in the usual doses. He says that the glycosuria was observed by authorities who have studied mercurial poisoning experimentally: Salkowski, Tolmatschew, Rosenbach, Heilborn, Lazarevic, V. Mering, Berg, Binet, Schröder, Graf, Richter and Karvonen. The mercurial diabetes has been attributed to the fact that mercurial poisoning rapidly causes a disappearance of the hepatic glycogen.—*Dr. Ch. Fauconnet, Münchener Med. Woch., No. 20, 1905.*

Prognosis of Melancholia.—In discussing this subject Dr. S. Grover Burnett, of Kansas City, Mo., says: These cases of uncomplicated melancholia get well if recognized early and promptly isolated under proper and competent treatment. If neglected they commit suicide, homicide or both, as is the case where the mother kills her children and then herself, or tend to become chronic and gravitate to the public asylum.* * * The suicidal tendency is strong in the incipency of the disease. Frequently the act is complete before the family physician has diagnosed melancholia from neurasthenia. So common is suicide to melancholia that I stated in the last annual report of my sanitarium work that "every case is suicidal in some degree at some period of the disease." Its importance is recognized in the fact that the practitioner sees twenty cases of melancholia to one of mania.* * * Of the 103 melancholias referred to in my reports, 47 recovered, 21 were to all appearances recovered but were removed too early to warrant using the term recovered; 20 were well on the way to recovery and would have recovered had financial reasons not necessitated their removal. This makes 88 recoverable cases out of 103 unselected melancholias.

Of the remainder, three died; one a hypochondriacal melancholia, one a senile melancholia and one a neglected melancholia agitata with acute exhaustion. Seven were discharged unimproved, two senile melancholias, four chronic stuporous melancholias and one stuporous melancholia of the menopause—all unrecoverable cases when admitted. Five recoverable cases remained under treatment, making 103 in all.

This tells us three things to do: Diagnose melancholias early; treat them early; treat them carefully, systematically and in isolation from family sympathies and worries and the uncomplicated cases will get well, otherwise we are largely responsible for the annual crop of mysterious suicides and the filling of the public asylums with chronics.—*Kansas Med. Soc. Jour.*

Anal Fissure.—Before resorting to radical operation palliative measures should always be tried. The most important thing is a laxative diet and soft bowel-movements by mild cathartics if necessary. On retiring each night there should be an injection of an ounce of olive oil, to be retained until morning, which, aside from its local beneficial action, will secure a soft motion. Next in importance to the regulation of the bowels, is that strict cleanliness should be maintained by bathing the anus night and morning and after each defecation with hot water. The parts should afterward be dried with a sterilized piece of gauze, and a pad of the same material placed over the anus and kept in position with a T-bandage. The fissure itself may be burned once a week with stick nitrate of silver. *Therapeutic Gazette* says pure ichthyol applied to the fissure with a cotton swab two or three times a week is much better in most cases than nitrate of silver. It seems to act like a charm in allaying the painful symptoms, and often a few applications will prove sufficient.—*Dr. Emory Lanphear in Am. Jour. of Clinical Medicine.*

Public Health Items.

Defilement of the Bathing Beaches of the Sea Coast of New Jersey—Prompt Action By Our Health Authorities.

The disposal works on Barren Island were destroyed by fire May 20, 1906, and the removal of garbage from the city of New York at once became a most embarrassing business. To meet the emergency it was transported to a point fifteen miles east of Gedney's channel and discharged into the ocean. As long as the service was faithfully rendered none of the garbage came ashore on the New Jersey coast, but during the week ending June 23rd high easterly winds prevailed and doubtless the labor and cost of towing the scows to the dumping ground in a heavy sea proved a very trying duty to the persons who were intrusted with this work, and the garbage was consequently discharged about six miles off Seabright. From this locality it was soon distributed along the New Jersey coast beaches from the Highlands to Point Pleasant.

Complaints were made to Governor Stokes and he called upon the State Board of Health and the Attorney-General to take such action as might be necessary to prevent a recurrence of the nuisance. The facts were brought to the attention of the Department of Street Cleaning in New York City, and assurance was given that the nuisance was due to the disobedience of instructions on the part of the persons who were in charge of the garbage boats, and that measures would be employed to secure compliance with the orders of the department in future. Since that time there has been little cause for complaint, and with the erection of a new plant for the disposal of the garbage of the city, the risk of defiling the New Jersey shores will terminate.

The act of the Legislature, approved April 8, 1903, is designed to secure improvement in the grade of the employees of local boards of health, and 135 persons have thus far been examined for fitness to perform the required duties and 32 health officers and 40 sanitary inspectors have been duly licensed. A circular (No. 110) has been issued by the State Board of Health, giving full information concerning the law and the examinations which are held under its provisions. The next regular examination will be held in the State House, Trenton, Wednesday, December 5, 1906.

The Mote and the Beam.—In connection with the interest manifested by the English in the shortcomings of the American meat industry, it is noteworthy that a London sanitary inspector, Mr. Foot, declares that the inspection system applied to the slaughtering business in England is a mere sham. He says: "There is nothing new in connection with the recent disclosures, except perhaps to make us wonder why we have gone to Chicago for our sensation."—*Editorial N. Y. Med. Jour.*

Yellow Fever and Dengue in Cuba.—Of the former two cases have been reported in Havana, with four suspects under observation. Sixteen cases of dengue were reported in that city during the week ending June 23. The previous week fourteen cases were reported, indicating that the disease is increasing.

. Bulletin No. 25, Hygienic Laboratory, Washington, D. C., is an excellent number, on "The Cestode Parasites of Man," by C. W. Stiles.

Yellow fever has also appeared in Mexico.

From June 1 to 17, seventeen cases occurred in Merida, with five deaths, and several suspicious cases are under observation.

Cholera in the Philippines.

On July 4 twenty-one cases and sixteen deaths were reported, of which four were Americans, one of whom died. Every precaution has been taken by the health officials to prevent its spread so that a wide-spread epidemic is not feared. The Philipinos fear of the health officials, however, which leads them to conceal cases, is the greatest obstacle in its control.

On the Isthmus of Panama malarial fever has greatly increased among the negroes and the hospitals are crowded to their full capacity. This is attributed to the rainy season and the abundant supply of anopheles.

Anthrax has been prevalent in the lower part of Cumberland county, and glanders in parts of Middlesex county. The State Board of Health has adopted vigorous measures to stamp out these diseases.

NEW MEMBERS OF THE AMERICAN MEDICAL ASSOCIATION FROM NEW JERSEY.

Barwis, Elmer, Trenton; Becket, George C., East Orange; Bloom, D. M., Newark; Condict, Arthur W., Dover; Conrad, Edgar K., Hackensack; Dias, J. Lawrence, Newark; Edwards, Sarah M., Newark; Lane, Frank B., East Orange; Meacham, Eugene A., South Amboy; Morse, J. H., Bridgeton; Pyle, Immanuel, Jersey City; Welshman, George O., Newark.

At the annual meeting of the American Medical Association, at Boston, Mass., May 28-June 1, 1906, the following members of our State Society are reported as having taken part: Papers were read by Dr. Philip Marvel, of Atlantic City, on "Some Clinical Observations in a Case of Acute Lymphatic Leukemia, Suggesting Infection as an Etiological Factor in the Disease;" Dr. Charles J. Kipp, of Newark, on "Retrolubar Neuritis Following Childbirth"; Dr. W. E. Darnell, of Atlantic City, on "Neuroma and Neurofibroma." The following took active part in some of the discussions: Drs. P. A. Harris, of Paterson; C. J. Kipp, of Newark; Alex. McAlister, of Camden; D. E. English, of Millburn; T. R. Chambers, of Jersey City, and W. P. Eagleton, of Newark.

The JOURNAL will be glad to print original papers from any source, preferably from members of the State Society, provided that they shall be of sufficient merit and shall be contributed to this paper exclusively.

Anonymous communications will not be published, but the name of the author of a communication will be kept secret if the editor is requested to do so.

The Medical Society of New Jersey does not hold itself responsible for the sentiments expressed by the authors of papers.

It will be satisfactory to all concerned if authors will have their contributions typewritten before submitting them for publication. The expense is small to the author—the satisfaction is great to the editor and printer. We cannot promise to return unused manuscript.

Authors may obtain reprints of their papers at cost, provided a request for them be written on the manuscript. Matter received after the 20th of any month cannot appear in the next issue of the JOURNAL.

Married.

Alfred Cramer, M. D., to Miss Anna Brown-Doughten, both of Camden, N. J., June 9.

Howard Crosby Voorhees, M. D., of New Brunswick, N. J., to Miss Marguerite S. Slocum, of Stapleton, Staten Island, N. Y., June 30.

Obituary.

Thomas C. Rhoads, M. D., New York University, New York City, 1865, formerly city physician of Weehawken, N. J., died suddenly in New York City, May 30.

David Clark Strachan, M. D., of East Orange, N. J., died at that place, June 23, aged 24 years. He graduated from the New York Homeopathic Medical School and Hospital in 1905.

Charles G. Towar, M. D., formerly of Atlantic City, N. J., died from sunstroke in New York City, June 30, aged 31 years.

Personal.

Dr. W. Blair Stewart of Atlantic City, has been elected first vice-president of the board of trade of that city. **Dr. Benjamin Gutmann**, of New Brunswick, has been elected a member of the staff of the Wells Memorial Hospital, there located; he has also been appointed health inspector of New Brunswick in place of Dr. S. V. D. Clark, resigned because of impaired health, after faithful and efficient service for ten years. **Dr. W. H. Murray**, of Plainfield, was registered at Jackson, N. H. **Dr. John G. Wilson**, of Perth Amboy, is spending July and August at Cape Breton, N. S. **Dr. F. M. Donohue**, of New Brunswick, is spending the summer at his summer home, "Cedarcrest," near Bound Brook, but makes almost daily trips to his city office in his auto. **Dr. Edward J. Ill** of Newark, is at his country home, Island Heights, N. J. **Dr. W. J. Chandler**, of South Orange, has returned from a Western trip. **Dr. M. J. Synnott**, of Montclair, has been touring Long Island in his automobile and **Dr. James S. Brown**, of Montclair, has taken an extensive auto trip to the Northern States and Canada. **Dr. Irwin H. Hance**, of Lakewood, is at Lake Placid, N. Y. **Dr. John L. Lund**, of Perth Amboy, has resumed practice after a protracted illness from inflammatory rheumatism. **Dr. Fred J. Hughes** has been appointed school physician of North Plainfield. **Dr. William C. Boone**, of Plainfield, after 25 years of service, resigned as a member of the Muhlenberg Hospital Medical Board July 9.

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THE VALUE OF TARTAR EMETIC IN THE TREATMENT OF TRAUM- ATIC TETANUS AND CERE- BRO-SPINAL MENINGITIS.*

By David St. John, M. D., Hackensack, N. J.
Third Vice-Pres't Medical Society of New Jersey.

The mortality in the diseases named remains so high notwithstanding the best efforts of our most skilled and painstaking clinicians to combat it, both by the serum and drug treatment, that we ask the profession to make trial of an old drug, which seems to possess a special value in relieving, if not curing, these dreaded diseases. The pathology shows a marked difference, but the symptomatology presents somewhat similar features, especially those produced by the effect of the different toxins upon portions of the muscular system, viz.: spasms and rigidity of a certain class of muscles tending to a fatal exhaustion.

Several years ago my friend, the late Dr. A. L. Vandewater, then medical director of the Equitable Life Insurance Company of New York, called my attention to the great success his associate director, Dr. Bross, had met with in the use of tartar emetic in the treatment of traumatic tetanus, when in charge, some years before, of a railroad hospital, in Costa Rica, South America. Traumatic tetanus was then very prevalent in that country, and the railroad employees, being ignorant and indifferent as to the proper care of wounds, very often developed tetanus following injuries of various kinds. Dr. Bross, after experimenting with different drugs, finally made use of

tartar emetic in large and frequent doses with such surprisingly good results that he came to regard it almost as much of a specific in traumatic tetanus, as we regard quinine a specific in malarial fever.

TRAUMATIC TETANUS.

Some months later there came into my service in the Hackensack Hospital, at different times, five cases of traumatic tetanus, all typical in their symptoms, which developed after the following injuries, viz.: pistol wound in the palm of the hand, wound between thumb and index finger from splinter, thumb crushed in sawing wood, and one proving fatal following vaccination. All were given large and frequent doses of tartar emetic which constituted the chief treatment. Dr. George F. Shrady, of our consulting staff, saw some of these cases, confirmed the diagnosis and approved the treatment. I will read brief reports of three cases which were as follows:

George Willie, German wheelwright, aged 53 years, of Etna, N. J., crushed the end of second finger of right hand while sawing wood on the 28th of September, 1898. He dressed the wound with lard and later with cartwheel grease, nothing unusual was noticed about the wound except slowness in healing. On October 10th, however, he felt some stiffness of the jaw, and on the following day of abdominal muscles and the muscles of the legs, particularly of the right. Not much attention was paid to this, but the stiffness continued growing worse so that on October 14th the teeth could be separated with difficulty and the body would stiffen in convulsions if anyone touched him.

Dr. Zabriskie, of Westwood, N. J., was called October 15th. He found the patient

* Delivered at the 140th annual meeting of the Medical Society of New Jersey.

confined to couch unable to move because of the spasms which occurred whenever he was touched or when light struck him suddenly, or on hearing noises. His teeth could only be separated one-half inch, and the patient was nourished by tube. Sleep was impossible owing to the frequency of spasms which occurred every two to fifteen minutes. On October 18th I was called in consultation. Patient was very much exhausted by frequent tetanic spasms; perspiration was profuse; thirst intense and respiration labored. I advised tartar emetic in one-fourth grain doses every two hours in addition to morphine, which was being given occasionally by Dr. Zabriskie.

On the following day I again saw the case, patient seemed a little more comfortable and not so rigid; wound of the finger was again dressed using hydrogen peroxide, iodine and then an iodoform dressing. That the patient might have more quiet and careful nursing, we advised his removal to the Hackensack Hospital, which was agreed to and the acting house surgeon, Dr. William Donoven, was left in charge of the case and very skilfully conducted his transportation. Patient had been unable to urinate for 24 hours, but on being raised from the couch, he expressed a desire and passed about ten ounces of urine. He suffered very much while being moved; the body was perfectly rigid from the jolting of the wagon, and later, from the stopping and starting of the train and blowing the whistle, he had tetanic spasms. On admission to the hospital, 6 P. M., October 19th, pulse was 120; temperature 101; the following treatment was ordered, tartar emetic one-fourth grain every 2 hours, and water ad libitum, which averaged 8 ounces every hour. As bowels had not moved for four days a high enema was given which caused an alarming spasm. The enema passed in about fifteen minutes with a little fecal matter; patient was then given calomel 10 grains, and powdered jalap 30 grains. During the night his bowels moved thoroughly and he slept four and one-half hours, the first in three days.

October 20th. Morning temperature 99 $\frac{2}{3}$, pulse 118; evening temperature 100 $\frac{2}{3}$; pulse 110. Patient was catheterized as he was unable to urinate voluntarily; spasms continued less frequently during the day, being more severe when taking nourishment; his breathing was labored and at times stertorous; perspiration free and constant. October 21st. Temperature 100, pulse 115; patient catheterized 10 A. M. Under chloroform

narcosis I amputated end of injured finger, patient feels a little more comfortable. In the afternoon he expressed a desire to bend his legs and, with slight assistance, flexed both legs on thighs and thighs slightly on abdomen. Perspiration continued profuse, patient slept from 10 to 12 P. M. October 22nd. After six hours of sleep patient feels much improved; slight spasms occur about every 30 minutes. Perspiration still profuse and patient drinks from 8 to 10 ounces of water and milk per hour; temperature 98 $\frac{2}{3}$ axilla; pulse 104, strong and full; in the afternoon patient complained of considerable soreness of muscles of abdomen and thighs; asked for whisky and was given one ounce; evening temperature 101 $\frac{2}{3}$; pulse 116.

October 23rd. Patient slept less last night and muttered to himself when alone; pain in abdomen less toward morning; about 9 A. M., while attendant was out of the room, patient attempted to get out of bed and had a very severe spasm with most marked opisthotonos yet noticed; temperature 99; pulse 108; talked to himself a great deal and picked at the bed-clothes; bowels moved well by a high enema. October 24th. Five hours sleep during the night and a decided improvement in general condition; morning temperature 99 $\frac{1}{2}$; pulse 100; evening temperature 100 $\frac{2}{3}$; pulse 104. Patient was seen by Dr. George F. Shrady, of New York, in the afternoon, who advised morphine when indicated by pain and tartar emetic continued; slight spasms occur occasionally. October 25th. Patient slept six hours; still some pain in abdominal muscles, particularly recti. A. M. temperature 101 $\frac{2}{3}$; pulse 110; interval between spasms lengthened. October 26th. Temperature normal; pulse 112; patient feels better and asked to be moved to window so that he could raise the blind and look out; perspiration not marked; still catheterized. October 27th. Temperature 99; pulse 102; paroxysms less frequent. October 28th. Very slight muscular twitching; slept well; temperature and pulse normal; at 6 A. M. was given a sponge bath; felt much refreshed and rested well all day.

October 29th. Patient is able to turn on his side and flex legs; temperature and pulse normal. October 30th. Patient urinated voluntarily; somewhat restless; temperature 98 $\frac{2}{3}$; pulse 94. October 31st. Tartar emetic stopped as patient slept well and abdominal paroxysms do not occur; at times nervous and irritable, but temperature nor-

mal. November 1st. Temperature normal; pulse 88; still some stiffness of muscles of neck and back, separates teeth about one and one-half inches. November 2nd. Patient sits up in bed after assistance in getting up. November 3rd. Patient walked across room and put on underclothes; sat up and read magazines; temperature and pulse normal. November 4th. Patient sat up several hours reading. Appetite good and general diet followed. From this time until discharged, November 12th, patient able to dress himself, move about room, etc. Wound of finger entirely healed; appetite excellent; temperature and pulse normal.

A. B., aged 19, American, farmer, strong, robust youth, admitted to the Hackensack Hospital 7 P. M., October 20th, 1903. Had been shot in the palm of the hand two weeks before; wound partially healed; temperature $99\frac{1}{2}$; pulse 98; respiration slightly quickened; jaw stiffened; tongue slightly bitten; pain in back especially along spine; spasms at frequent intervals; takes nourishment slowly and with difficulty, choking easily; bowels constipated; unable to urinate; bowels moved with calomel and jalap. Perfect quiet being essential, since spasms are so easily excited, patient was placed in a large darkened room and special day and night nurses assigned. He was ordered tartar emetic one-fourth grain every 2 hours, day and night; received an occasional dose of morphia and placed on a milk diet; wound was opened freely; bullet and wadding removed; thoroughly curetted and cauterized with carbolic acid and then dressed with iodoform gauze and a moist bi-chloride dressing. During the next four days temperature gradually increased and pulse rate quickened; nauseated but unable to vomit; refusing at times to take milk. October 25th, 7 A. M. Pulse 120; temperature $104\frac{1}{2}$; no sleep during night; paroxysms at frequent intervals; trembling and twitching of muscles almost continuously; breathing labored and gasping at times; the difficulty in taking nourishment, which had gradually increased, owing to muscular rigidity, became so great that nutrient enemata were given and continued at intervals when required throughout illness.

Temperature ranged during the next ten days 102 to 103, with no morning remissions; morphia $\frac{1}{4}$ grain was given occasionally.

Will here give nurse's record for night of October 27th. Restless and delirious, growing worse at 12 midnight; takes very

little nourishment owing to difficulty in swallowing; slept from 4 to 4.30, awoke with paroxysms and screaming from pain; between paroxysms, however, face bore more calm expression; respiration regular; jaw dropped; after 20 minutes was able to swallow quite well, then became continuously restless and delirious as before; free perspiration. October 28th, A. M. More quiet and less muscular rigidity. October 29th. Passed a very good night; voided urine for the first time since admitted, and was only catheterized a few times afterward. October 30th. More quiet than usual; general relaxation and tartar emetic given at longer intervals. November 1st. Slight muscular contractions between 2 and 2.30 A. M. November 2nd. Contractions more marked during the night and complaints of pain in the back; tartar emetic again given every 2 hours. November 3rd. Passed a very quiet night. November 4th. Rested very well during the night but still very stiff and slight convulsions.

November 6th. Pulse 96; temperature $98\frac{1}{2}$. November 8th. Twenty-eight days after admittance, complete relaxation; temperature normal; pulse 96. November 8th to 15th. Temperature about normal; pulse 90 to 96; passed very good nights and only occasional contractions. November 16th. Marked contractions. November 17th. Slept quietly during the whole night. November 21st. Few contractions during the day. November 21st to 25th. No change. November 25th. Temperature and pulse about normal; slight contractions at intervals during afternoon; pain in back between shoulders; more severe paroxysms than during P. M., but slept well after midnight. November 26th, 27th and 28th. A few slight paroxysms; tartar emetic every four instead of every two hours. November 29th. Slight rigidity. December 1st. Tartar emetic discontinued. December 1st to 14th. No paroxysms though muscles stiff at times. December 14th. Pulse 120; temperature 102.3-10 to 103; but responded to quinine. December 23rd. Discharged.

——— Mink, aged 11, American, male, June 15th, 1902, splinter from barrel hoop ran through hand between thumb and index finger; entrance wound healed quickly, but splinter caused abscess pointing on palmar surface which was opened by his father with a jack-knife; this wound also healed completely. June 27th—twelve days after injury, while riding on a market wagon, jolting of same excited a mild

spasm and on alighting found locomotion so much interfered with that he was compelled to stop every twenty-five feet with a spasmodic stiffening of lumbar muscles. I was called in the same day and prescribed tartar emetic $\frac{1}{8}$ grain every three hours day and night. Tetanic convulsions continued for four or five days, increasing in severity, more marked in left arm; teeth could be separated only one-half inch; pains in back required a mild opiate, only three or four doses being given as required; saline cathartics were given as indicated. At the end of two weeks tried to stop the tartar emetic but patient immediately grew worse, and was given medicine every four hours until July 13th, twenty-eight days after the first spasm; at this time patient was able to sit up in rocker though still quite stiff. Three days afterward walked across the room and made rapid recovery, without further medication; temperature ranged from 99 to 102 during the first two weeks and then gradually dropped to normal.

CEREBRO-SPINAL MENINGITIS.

During the past winter in the service of my colleague, Dr. Conrad, at the Hackensack Hospital, four cases of cerebro-spinal meningitis were admitted to the contagious ward, all presenting the characteristic symptoms in a marked degree. It was my privilege to see the first case in consultation before admission and, by the courtesy of Dr. Conrad, all of them daily during their detention at the Hackensack Hospital, watching carefully their condition as well as the effect of the treatment. At the consultation, noting the likeness in the muscular condition to those in tetanus, although produced by different toxines, and remembering the good effects of tartar emetic in the cases of traumatic tetanus before mentioned, at the suggestion of Dr. Conrad, trial of this drug was also made in these cases with the result that all recovered. Dr. Carlos F. MacDonald, consulting alienist, saw these cases, confirmed the diagnosis and approved the treatment.

May 12th, 1905. Patient, John Zeliff, aged 16, returned from work complaining of headache and chills; vomited; and was given 4 grains of quinine and put to bed. Had a very restless night and in the early morning had a convulsion; saw the patient first about May 13th. He was then in a semi-comatose condition; breathing stertorous, could be roused but could not talk and recognized no one. Kernig's sign present; temperature $101\frac{3}{5}$; pulse 110; gave sodium bromide in

20 grain doses every 3 hours; at 2 P. M. patient was delirious and threw himself about the bed, screaming and requiring several men to hold him in the bed. Dr. St. John saw the case in consultation during the day and diagnosis of epidemic meningitis was made; patient was removed to the hospital annex same night, it was necessary to strap him as it was impossible to keep him from throwing himself out of the bed. He was at once put on tartar emetic $\frac{1}{8}$ grain every 3 hours; sodium bromide 20 grains every 4 hours, and spirits of nitre 15 minims every 4 hours; nourishment, milk and eggs. He was given hyoscine hydrobromate hypodermatically for first three nights to control mania; could not urinate and was catheterized every 8 hours. May 14th. Temperature $101\frac{1}{5}$; pulse 107; respiration 25; patient developed strabismus. Dr. Macdonald saw patient in the evening and confirmed diagnosis. May 15th. Developed herpes labialis. May 16th. Temperature reached the highest point, 103; pulse 110; respiration 27. May 17th. Urinated voluntarily for the first time, nitre was discontinued, tartar emetic reduced to $\frac{1}{8}$ grain every 4 hours and patient given small dose of K. I., 5 grains every 4 hours; temperature $100\frac{3}{5}$; pulse 100; respiration 20; was rational for the greater part of the day, and tartar emetic was discontinued. May 24th. Patient was allowed a soft diet and sat up; recovery was uneventful from this time, strabismus alone remaining.

Theodore Jacobus, aged three years; colored; admitted to the isolation ward of the Hackensack Hospital, May 12th, 1905; under the care of Dr. Conrad. Diagnosis of cerebro-spinal meningitis was confirmed by Dr. Carlos F. MacDonald, of New York. Patient taken sick several days previous with fever, vomiting, headache, muscular rigidity and convulsions; on entering temperature was $100\frac{1}{5}$; pulse 108; respiration 20; very restless; head retracted; rigidity of cervical muscles; convulsions and slight delirium; Kernig's sign present. Tartar emetic every 3 hours in 1-24 grain doses and 3 grains of sodium bromide every 4 hours was ordered; diet milk. First week temperature ranged $100\frac{1}{5}$ to 103; pulse 115 to 120; respiration 25 to 45. Patient showed signs of improvement after third day of treatment: not so restless and less rigidity; would also take nourishment better. During the second week temperature gradually lowered; pulse somewhat slower; respiration 35 to 50; convulsions very much less severe

and at longer intervals; marked muscular relaxation. Ten days after admittance, daily dose of tartar emetic was diminished and on the twelfth day was given only 1-15 grain every 6 hours. This amount was continued until the end of the 14th day, when it was discontinued. The following day the patient became more restless with slight return of muscular rigidity, tartar emetic 1-14 of a grain every 4 hours was again given and continued until the 19th day, when it was discontinued. On June 6th, six days later, patient was restless and cried frequently, a single dose of tartar emetic was given but, as it caused vomiting, was not repeated; this was the first time during treatment that the emetic effect was produced. Patient was discharged June 11th, one month after admittance.

Agnes Napp, aged 10. Patient complained in the evening of June 10th, 1905, of feeling cold; was very restless during the night, dreaming and talking in her sleep. June 11th. Complained of headache and was feverish all day; in the evening head moved back and forth (nodding movement) involuntarily. June 12th. At 1 A. M., she had a convulsion and moaned and screamed at intervals during the night; was called and saw patient for the first time at 6 A. M. She was delirious, jumped up in bed; had marked stiffness of the neck; Kernig's sign; did not recognize family; diagnosis of cerebro-spinal meningitis made and patient given tartar emetic $\frac{1}{6}$ grain every three hours; sodium bromide, 12 grains, every four hours; temperature ranged from 102 in the morning to 103 at night during this day; by night she quieted down considerably and recognized mother and sister; developed squint. June 13th. Temperature normal; pulse 100; head was more retracted but patient was more rational and knew attending physician; extremities were cold; hands clammy; in afternoon temperature went up to 101 but condition remained good. June 14th. Temperature 102 $\frac{3}{8}$; condition fair, delirious at times but would know members of the family if spoken to several times. June 15th. Temperature 103 $\frac{3}{8}$ and patient seemed more restless. June 16th. Temperature 103 $\frac{3}{8}$. As temperature had been on the increase for several days and patient was not showing any improvement mentally, the dose of $\frac{1}{6}$ grain every two hours was in the evening increased to $\frac{1}{4}$ grain every two hours. The effect was almost immediate, for by the morning of June 17th temperature was nor-

mal and patient was very bright, complaining only of headache; head was still retracted.

June 18th. Temperature normal; still had headache but condition otherwise favorable. June 19th. Patient sat propped up in bed looking at the funny sheet of paper; headache all gone; still had stiffness of the neck and strabismus. Interval of giving tartar emetic increased to four hours; no other medication at this time. June 21st. Interval increased to six hours. Patient sat up every day after this and stiffness of neck gradually disappeared.

This case shows beyond question the benefit of tartar emetic, as we believe do the two previous cases under this treatment, no other medication was given, the amount of sodium bromide being too small to influence the condition. The result from the tartar emetic was at first prompt, as the patient became rational at intervals after twelve hours treatment and temperature reached normal in twenty-four hours. Then for three days temperature increased steadily and patient grew more restless, and again on increasing the amount of tartar emetic, twenty-four hours brought the temperature to normal, where it remained. Patient was ill thirty-six hours before receiving medical attention, and nine days from that time was sitting up in a chair. Tartar emetic was given two weeks in all, after which a mild tonic, and recovery was complete.

Tetanus is an acute infectious disease, caused by the entrance into the body of a distinct organism, "the bacilli of tetanus." The means of entrance is usually through a surface wound, which in some cases may be so small as to escape the notice of the patient.

An interesting peculiarity is the fact that the toxine for a time remains about the site of entrance and from this focus the toxine is transmitted. Meyer and Ransom prove that the toxine passes to the central nervous system through or along the nerve trunks. Brooks states that the post-mortem changes found are degeneration of the nerve cells of the spinal cord. The lesion usually found in cerebro-spinal fever is an exudate of an inflammatory character, both of the pia-arachnoid covering of the brain and spinal cord; this exudate is most apt to be found at the base of the brain or on the dorsal surface of the cord, in the thoracic and lumbar regions. Brooks says that in the case of the spinal cord, the exudate is, ordinarily not so diffuse, the compression

from the anatomical arrangement of the cord and its membranes is less, and the pus is generally arranged more in patches than in the diffuse manner seen over the brain.

In my experience there is very little difference as to the relative amount of exudate found at various levels of the cord, sometimes the amount is greater above the cervical enlargement, at other times in the dorsal or lumbar regions.

Admitting, that from the known pathology of these diseases, it is difficult to establish or prove a theory of cure with tartar emetic, whether the drug has a direct effect upon the toxins, as has quinine upon the toxins of malarial fever, as Dr. Bross believes, or whether its effect is by elimination of the poisons, through its action on the skin, kidneys, intestines, etc.; or whether its chief value is in diminishing reflex excitability of the spinal cord and in producing a general relaxation of both voluntary and involuntary muscles, thus controlling or modifying spasms and rigidity and preventing exhaustion until the system throws off the poison, are questions which remain in doubt.

We also admit that the successful treatment of eight cases is a small number from which to prove the value of a drug, but as these cases confront us with serious conditions rather than theories, and as results are what we work for, and with the much larger experience of Dr. Bross in tetanus, we feel justified in reporting these cases and respectfully ask the profession to make further trial of this drug in larger doses if need be in the treatment of these diseases when opportunity offers.

A letter from Dr. Carlos F. Macdonald, of New York City, consulting alienist to the Hackensack Hospital, is herewith presented:

New York, June 14, 1906.

DR. DAVID ST. JOHN, Hackensack, N. J.

My Dear Doctor:—

Replying to your request for an expression of my opinion as to the correctness of the diagnosis and the efficacy of the treatment followed by you in the cases of John Zelfiff, aged sixteen years, and Theodore Jackson (colored), aged three years, whom I saw in consultation with you and Dr. Conrad during the epidemic last winter, I would say: In my opinion, these patients both presented well marked symptoms of cerebro-spinal meningitis, as shown by the rapid onset of prodromata that are characteristic of nearly all of the infectious fevers, namely, the gastric disturbance, vertigo, restlessness, insomnia, headache, rapid pulse and rise in temperature, which are soon followed by pain and muscular rigidity in the cervical regions, with more or less nuchal re-

traction; also the characteristic abdominal retraction and general muscular rigidity, which rendered movement of the body extremely painful. Kernig's symptom was present in each case. There was also a tendency to mental confusion and mild delirium. The medicinal treatment which was suggested by you and Dr. Conrad consisted of the exhibition of tartar emetic in 1-6 grain doses in the case of Zelfiff, and 1-10 grain doses in the case of Jackson, every two hours with the result that the symptoms in each case were markedly ameliorated almost from the first, and both cases terminated in recovery.

I also saw in consultation with you in 1902 a patient named Bross, who was suffering from well marked tetanus, following a gunshot wound of the hand, which occurred about twelve days previously. This case was also treated by tartar emetic in $\frac{1}{4}$ grain doses, every two hours, day and night, and the result was a complete recovery. I was favorably impressed with the apparent efficacy of the drug (tartar emetic), both in the cases of cerebro-spinal meningitis and in the one of tetanus, and would strongly recommend a further trial of the remedy in doses up to the full point of tolerance in any future cases of these affections.

Sincerely,

CARLOS F. MACDONALD.

DISCUSSION.

Dr. Richard Ellis, of New York City.—During the past five years I have repeatedly heard Dr. Bross mention this treatment for tetanus. In eighteen years I have seen three cases and they all died. Dr. Bross' statement seems almost impossible and I have asked him to publish his results but he has not done so. Day before yesterday he called me to his office and said, "I want you to go to Atlantic City, and you must go." I said, "What shall I go for." He answered, "I want you to go and present for me the following, which I have dictated to my stenographer."

Dr. W. R. Bross, of New York City.—Some years ago I received an appointment as Chief Surgeon for a railway under construction in the Tropics. On my arrival there, the road having been under construction for some time, I found affairs in the medical line in a most pitiable condition. They had an ignorant class of labor, mainly negroes and natives (Spanish), who knew very little about hygiene as we understand it. They were very careless in the matter of slight wounds. I was soon appalled by the number of cases of acute traumatic tetanus which came to me for treatment. I had over 140 cases in six years (this statement is from memory; as near as I can recollect there were 147 cases) *without a single recovery*. No matter what I did the result was the same. The residents, on inquiring what was the matter with a patient who was ill, if told that it was tetanus, simply shrugged their shoulders and gave up the ship. On my arrival there I found that the popular treatment for malarial troubles, which were mainly the diseases with which they were affected, was tartar emetic. This was sold in 1-ounce bottles in all the shops. Any family that had the means possessed a bottle of this drug. The carelessness with which this drug was handled was surprising. They took an ordinary case knife, dipped it into the bottle, took anywhere from five to twenty grains, mixed it with water and drank it all. Their idea was that malarial

fever was caused by a torpid liver; that by producing intense vomiting the liver was squeezed and the bile expressed. Some recovered, but many died. Therefore, after my experience with numerous cases of tetanus, and my failure to get results, I began to look around for some drug to assist me. I selected tartar emetic as being a spinal depressant. In view of the experience above quoted, I was not afraid of the drug in doses larger than those given in text-books. My first case was that of a Spaniard who had been injured in a fight. In that region instead of using their fists they drew the machette, and some very serious wounds was the result. This patient had the right parietal eminence clipped from his skull. When I saw him it was hanging to the scalp, with some protrusion of the dura mater. The right arm was fractured, the external condyle cut off, and the elbow joint opened. Another wound was on the left hand, passing between the fingers; it fractured the first metacarpal bone and severed the tendons. The tendons were sewed up, the joint was washed out, fragments of bone were removed from the skull, a compress was applied, and he was placed in the hospital, as he was in a septic condition. The next day tetanus developed. He was put on $\frac{1}{4}$ -grain doses of tartar emetic, $\frac{1}{8}$ -grain doses of sulphate of morphia, and 5-grain doses of sulphate of quinine every two hours, kept up day and night. At the end of the fifth day the convulsions had subsided, when the dose was reduced. I was then called away to the interior to attend another case. I did not return for five weeks. The tetanus had all disappeared, but the elbow joint was enormously distended by pus; he had exhausting diarrhoea, a temperature of over 104, and was in a septic condition. Free counter openings were made in the joint. In spite of all he had gone through he recovered. Four other cases were caused by slight wounds, such as toes and fingers being amputated mainly by iron rails falling upon them. On account of the nature of the injury the hemorrhage was very slight. Many of the men continued at their work and came to the hospital to have their wounds dressed at the end of the day's work. Tetanus usually developed in twenty-four hours. The same treatment was administered and they all recovered.

The last case was that of a negro boy, eighteen years of age. He had a toe amputated by an iron rail falling upon it. This was one of the most severe cases I have ever had. He was in a constant state of opisthotonos until the end of the eleventh day. His convulsions were very severe. I had to remove him from the canvas cot and make a bed for him on the floor, as he tore right through the canvas. He had ulcerations at the back of the head and on both heels. His pulse grew very weak and it was difficult to administer nourishment. This is the only case that received any addition to the treatment, and this was in the shape of whiskey. On the morning of the eleventh day I found him in a thoroughly relaxed condition. The dose was immediately reduced to three doses a day, till he recovered.

From my experience I believe that tartar emetic is a good specific in this disease. Whether tetanus is a self-limited disease, or whether tartar emetic has some effect upon the bacilli or the toxin, I am unable to state. From the experience which Dr. St. John has had in the treatment of spinal meningitis, and his splendid results in the cases in which he tried this treatment, it may be that its

action is that of a spinal depressant. In my cases I obtained good results within ten days. The last case was the only one that ran over ten days; on the morning of the eleventh day he was the limpest man I ever saw. We had numerous cases of idiopathic tetanus, but they were so common that no record was kept of them. I kept in stock the powders above mentioned. As bottles were very scarce, the dose was put up in papers and we gave out six powders to a man. No deaths occurred that I am aware of. I tried to trace them, but never found a patient who had taken more than four powders.

I cannot speak too highly of Dr. St. John's courage in adopting this line of treatment on the slight evidence that I was able to offer him, and I congratulate him most heartily upon his success. I trust that it may impress our professional brethren sufficiently to induce them to try it.

There is one point I would like to make, that is the intensity of the disease in the Tropics. In fact, all the diseases in the Tropics are very much more acute than we experience here, and a case of acute traumatic tetanus near the Equator is indeed a very formidable disease.

Dr. Ellis.—In other words, Dr. Bross lost from 1880 to 1886 140 cases of traumatic tetanus. Then the railroad construction work was ended so that fewer cases were seen. In 1887 he treated these five cases of traumatic tetanus, with no deaths. Three of these cases were Spaniards—two were negroes.

SYMPOSIUM ON NUTRITION DURING THE FIRST TWO YEARS OF LIFE.

(Continued from page 46.)

FIFTH PAPER.

THE ETIOLOGY OF RACHITIS, SCORBUTUS AND CRETINISM.

By August Adrian Strasser, M. D.,
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Among the nutritional disorders that involve the first two years of life, the three supreme conditions, which by their fearful present manifestations and, in the event of continued life, by their future effects on every sphere of human activity, are those of rachitis, scorbutus and cretinism. Because then of their inroads, their mortality and the after-effects in later life, should the poor unfortunate not succumb, it behooves us to get as clear a conception as possible of the causes that lead up to their appearance. Unfortunately of the three conditions only one has been put any nearer solution; around the others still cling the mists of doubt and uncertainty, of dispute and guesswork; and to reach a conclusion is simply a matter of choice and mental bias, for the definite scientific truth is thus far in abeyance.

Now to approach the known first. For

many years cretinism has been the subject of comment and study; and on the noble work of Kocher we must rely for our early facts. He established the knowledge that goitre and cretinism, *i. e.* goitrous and non-goitrous myxœdema, are endemic in certain places and conclusively proved by fact and experiment that in the drinking water of these endemic foci we had the etiologic factor. It remained for Gull, Murray and Horsley to establish beyond a doubt that the presence or absence of the thyroid gland was the etiologic factor *in* the body, be that of soil, climate, or water whatever it will *outside* of the body. By their experiments, the establishment of myxœdema at will, and its eradication by the ingestion of the substance of the thyroid of the same or other animals, was proven beyond a doubt and there only remained to explain the "how" of the action. Here too unfortunately much is still theory. Whether we follow Shiff, who thinks that the thyroid elaborates some substance necessary for the correct metabolism of the nervous system, or preferably take Horsley's view, that the thyroid eliminates the mucin of the blood, turning it into useful constituents of the body; in any event, it is certain that the absence of the thyroid, as such, be it a congenital defect or the result of a postnatal inflammatory process, or even the effect of a low grade of infectious fever that has influenced the thyroid, causes the appearance of that peculiar modification of metabolism in the body that we know as cretinism. Just how the process is accomplished is, as was said, still a matter of dispute; the interrelation of ductless glands has, however, in the last few years received very close study and, while the fruits of these investigations are not yet ready, there has been a decided advance in our knowledge of the subject.

In a few words they amount to this—That series of organs or bodies whose functions have been mysteries so long, now become of vital importance in the economy of the human organism; the thyroid, spleen, pancreas, pituitary gland and the sexual glands are not the apparently useless appendages they seem, but each elaborates in its interior some necessary substance in the metabolism of the ingested food or the tissue food already elaborated by the organs of digestion and circulation. Lorand in his recent monograph and lectures has conclusively shown that inhibition of one gland or the interference with the function of any one of the series has some subtle but noticeable

effect on the function of the rest of the series; their interrelation being so intimate and their mutual inter-reactions so necessary that the slightest change in their bearings throws the entire economy in an uproar. With this definitely known it is not strange that in the occasional cases of sporadic cretinism it is of moment to get a history of an infectious fever or even a prenatal thyroiditis, dependent on some maternal circulatory excitement, be this of a feverish type or a severe emotional strain, and that given, the lack of thyroid activity, even though goitrous enlargement or cystic conditions seem to belie the absence of gland tissue, it explains the early occurrence of infantile myxœdema.

So that to conclude this part of the subject, the statement of our present knowledge is as follows: The marriage of goitrous parents in endemic foci of goitre procreates cretinoids; sporadic cases of cretinism cannot be traced to similar infections. However, the same reason is at the bottom of both conditions. In the one the goitrous antecedents influence the thyroid growth in the foetus; in the other, sporadic form, prenatal, natal or postnatal thyroid inflammatory involvement explain the occurrence of infantile myxœdema of its various types. Its occurrence established, the effects are well known, thyroid influence being no more exerted on the fluids of the body, mucin runs riot in the tissue and plays havoc with the general metabolism, influencing as I have shown in a former study, food and air metabolism, limiting or modifying excretion, and eventually by overexerting other glandular structures, superinducing other derangements of the general economy and causing thereby decreased resistance to invasion of disease and thereby death.

Now let us turn to the other extreme and examine the etiology of the condition of deranged nutrition known as scorbutus, or more accurately Barlow's disease, according to German writers, who, especially Heubner, have shown that it differs clinically in many ways from the scurvy of the adult and has nothing in common with rickets. It is not by any means a common disorder, and in general practice in many quarters a rarity. In tenement house conditions, with squalor and low-food value, the physician whose work lies there, or who sees these patients in the clinic, is more likely to get it under his observation. The fact that the hemorrhagic condition, involving periosteum and bone, is unaccompanied usually

by inflammatory processes points out to us that the etiology lies somewhere in the process of nutritional metabolism and is not purely an infective process. But here again, when we come to examine more closely, there are only glittering generalities. For instance, we know that therapeutically cases of infantile scorbutus react most satisfactorily; and by induction it must be the lack of these antiscorbutics that produce the disease. But why in the one case feeding with sterilized milk of a certain mixture should produce the disease in one child and not in another is still a quandary. Predisposition does not cover the case; you may do as Biedert has done, cure a case that has been evidently produced by underfeeding with a sterilized milk, by giving larger quantities of the same sterilized milk, and its explanation remains as foggy as it was in the beginning.

I have no patience with these seeming explanations. To be frank and say we don't know, but will work on to find out, is better than in a pseudoscientific way to look at the stools, shake our heads, hold learned disquisitions on baby-feeding to whatever audience can be mustered from the household, blame the mother that she cannot feed her child, blame the child that it does not digest the food as we modify it, modify the milk so one day and promptly change next day to another mixture, even though sufficient time cannot have elapsed to see by the stool whether or not the digestion has been rightly accomplished; that, gentlemen, is farcial and leads us nowhere, and the children in our care to their grave. From the data in our possession accuracy in diagnosis and efficacy in therapeutics is much more easily gained by careful study of the patient as a whole than by a cursory view of his excretions; and to be interested more in the presence of greenish mucus or coloring matter in the diaper when the head or lungs or surgical anomalies are the cause of the difficulty, that is worse than farcial; it is a mental defect in the attendant, a monomania, a fad. Unfortunately this narrow view of pediatrics is gaining a clientele in some quarters; and it brings unmerited derision upon those who follow pediatrics in its full sense; who deal with all phases of disease as seen in childhood and do not try to reduce the equation of hernia, pneumonia or meningitis to a constant modified milk formula.

But to return to our subject itself. In its manifold manifestations and protean

types, infantile scorbutus always in the end follows a marked course; and whether the hemorrhagic condition involves periosteum, bone, superimposed muscular structures, mucous membrane of the mouth or gums in teething children, or whether, as Morse has pointed out, renal hemorrhage is our first guiding symptom, the etiologic factor stands out clearly, some deficiency in the general make-up. And inasmuch as the fresh fruit juices promptly and permanently cure the condition, there can be no gainsaying the fact that it is the same lack of these same vegetable citrates and malates that in years gone by produced an analogous condition in the adult. But even that does not explain; it announces the fact as based on experience; it is empirical and unfortunately that will have to remain the case until the physiologic processes in normal digestion shall have been settled for good and all.

If we have been wallowing in the slough of uncertainty thus far, we fall into worse when we go into the subject of rachitis. Although it was in 1650 that the Commission of Whistler, Boot and especially Glisson, started to work on the then newly described disease, and although what has since been written on the subject would fill a good-sized library building, even the present day is only full of theories and one is perforce driven to seek the small grain of truth inherent in them all, thus getting a composite view that comes nearest the fact and winning an etiology that has the merit of plausibility even if not demonstrable as proved. The theories of the etiology of rachitis may be variously subdivided; either as to time of their promulgation, or as to similarity of points of view. (1) The theory that assumed lack of calcium salts in the food; (2) their malassimilation; (3) their hypersecretion; these are one group. (4) The theory of insufficient or wrong feeding, a group by itself. (5) The carbon dioxide theory of Wachsmuth; (6) the carbon monoxide theory of Mayer form another group. In a fourth group is the theory (7) that assumes intoxication with toxins from intestinal bacteria and (8) that there is a true bacterial or specific invasion, and (9) Stoltzner's theory of a false metabolism due to a lack of secretion from the suprarenal glands. While in a fifth group we may place the theories of (10) heredity, (11) Kassowitz's embryological factor found in impure air and great humidity, and (12) Parrot's attempt to identify it with congen-

ital syphilis, which is mentioned simply for historic exactness.

Let us look into the validity of each a little more closely. Early in the history of this problem Glisson came to the conclusion that the causes of rachitis were to be found in unfavorable hygienic environment and climates with great humidity, over or wrong feeding, lack of air, sunlight and sun-warmth. But the question of feeding as the sole etiologic factor has received few points in support and many to combat it. The experiments of Chossat (1842), Friedleben (1860), Milne Edwards, Jr., (1861), Tripier (1874), Voit (1880) Troitzky (1897), and Baginsky (1882), were not so absolutely free from doubt, but that Spillman, in 1900, could controvert them successfully. As one of the many causative agents, the truth that to improper feeding must be ascribed some of the rachitic manifestations, was shown by Senator to be somewhere between the stand taken by J. Petit, who taught that early weaning formed the principal cause of rachitis, and Zeviani and his adherents, who believed that it was caused by precisely the opposite error, namely, by keeping the child at the breast too long a time. Senator thinks both views in a sense legitimate. "The evil does not lie in the normal mother's milk but in the fact that when the infant is prematurely weaned the nourishment substituted for the mother's milk is unsuited to its digestive powers and the requirements of its organization; while on the other hand, where it is kept too long at the breast the milk alone becomes insufficient for its nourishment." This is as true to-day as when it was written (1877). When toward the close of the eighteenth century and early part of the nineteenth century the more exact chemical and histological methods came into being, the one main symptom, the bone softening, was given very close scrutiny and the lack of lime salts in the bony structure of the rachitic gave rise to a number of chemical theories to explain their absence. The claim that this deficiency was primarily due to a decreased ingestion of calcium salts was successfully disproved by the analyses of the breastmilk of women whose nurslings developed rachitis, made by Friedleben and others. They concluded that there can be no question of a deficiency of lime salts in the nourishment; all the more inasmuch as cow's milk, containing four to five times the amount of lime that is in human milk, was generally reputed to be the cause of rachitis, yet it could under no circumstances be con-

tended that there was a deficient lime content.

Even sterilization, which, according to Marfan, precipitates about 50 per cent. of the lime salts, much of which is, however, redissolved on cooling, does not decrease the lime content enough so that a real deficiency results. Besides it is not possible to produce rachitis in animals by the inhibition of calcium ingestion as Stoeltzner and Miwa, in 1898, and Spillman, in 1900, proved by their careful experiments and their painstaking histological labors, which showed that in young animals a deficient lime absorption or ingestion produced what on first sight seemed to be a true rachitis, but proved to be only an osteoporosis and changes in the periosteum, but not true rachitic changes. Besides in this osteoporosis Voit proved that the soft parts take part in this deficiency of lime, while Brubacher was able to show that this did not obtain in true rickets, where the lime remained normal in the softer tissues and organs. The other point was that there was not actual lack in the food of calcium salts but their malassimilation. Zweifel claimed that the apparent abundance of lime salts in cow's milk went for naught, being precipitated in the intestine in an insoluble form; this was combated by Soxhlet, who, however, did no better, for he claimed that the malassimilation was due to the fact that cow's milk did not find the necessary quantity of hydrochloric acid to dissolve the lime salts that were not in solution and that thus a deficiency was produced. But the fact that rachitis occurs in naturally and artificially fed children in pretty nearly equal numbers, and the fact that other acids in the stomach and even peptones, alkaline in reaction in the intestinal tract may, according to Baginsky, act as solvents, make such a lime deficiency as an etiological factor of doubtful value. Also the experiments of Rüdell (1895), and Rey (1894), in feeding lime salts, gave but slight differences in the assimilating powers for these salts in normal or rachitic children.

There is left the third phase of the question—the unnatural loss of lime salts by excretory functions. This necessitates the assumption of an acid intoxication, that would dissolve the bone salts and pass them out in the excretions. However, the determination of the alkalinity of the blood of rachitics gave normal readings and the amount of lime excreted in feces and urine allowed no definite decision on this point. Marchand and Heitzman put forward the theory

that the hyperformation of lactic acid, which of course is easily produced in the infantile stomach, caused the lime salts to pass through the intestinal tract unaltered. Ingenious is the CO_2 theory of Wachsmuth (1895), and still more convincing the CO theory of J. Mayer (1903). The former looks upon rickets as a chronic CO_2 poisoning, or, as he says, an "asphyxia of the growing bone." He argues that normally small amounts of carbonic acid gas are constantly circulating in the blood, and producing an interchange of lime salts in the tissues—the normal metabolism in the body. In beginning rickets there is a proliferation of the blood vessels at the osteochondral junction and necessarily a more active metabolism at that site. Now given increased CO_2 intoxication from poor hygienic surroundings, disturbances in the respiratory or intestinal tract, where the lactic acid is converted into CO_2 it readily produces a venous congestion, the splenic tumor, etc. This must, however, be answered by the fact, that even Glisson acceded to, that there is as much rickets among the progeny of the rich who have no difficulty in procuring plenty fresh air as there is in those of tenement dwellers; and also that where there is congenital increase of carbon dioxide in the blood, as in "blue babies," there is no increased proneness to rachitis; moreover, the above mentioned blood experiments of Stoeltzner failed to reveal any increase of carbon dioxide in the blood of rachitics over the normal and average contents.

Even more interesting is the theory expressed by J. Mayer (Fortschr. d. Med. 1903, S. 1145). He concludes from the bone changes and the splenic enlargement that we have in rachitis a disease of the blood in the same sense as we speak of chlorosis and leukaemia as such. In rachitis he claims we have a chronic carboxidaemia of the child's system, caused in part by the large contents of the usually administered artificial foods and partly by the lack of nascent oxygen or ozone in the surrounding air. Therefore he wishes to explain the splenic enlargement as an hypertrophy of overuse and by its size gives us an index of the amount of intoxication from which the child is suffering. But unlike Wachsmuth, the infection is held to be due not to CO_2 but to CO ; the difference in the infection being evinced by the difference in symptomatology. Ashby, in the *Encyclopedia Medica*, says, "The trend of modern opinion is rather in the direction of seeing

in rickets the results of the absorption of toxins from the alimentary canal, which are formed during a previous period of chronic indigestion. The sweating, the muscular paresis, the laryngismus and the convulsions suggest the presence of toxins in the blood which have been formed in the alimentary canal from the maldigestion of the proteids, fats or starches in the food. It is possible that several allied toxins may be formed which give rise to special symptoms. Thus in some cases the bone changes are most in evidence; in others the muscular system chiefly suffers. In other cases convulsions, tetany and laryngismus are present, while in others they are absent first to last. Thus it would seem likely that rickets is the result of a peculiar form of chronic dyspepsia in which certain toxins are formed from bacterial action and it is the passage of the toxins into the blood from the alimentary canal that gives rise to the pathological changes which take place in the disease." This is a clear description of the standpoint that most writers of to-day assume on this question and, as you see, embodies the facts as shown in the second and fourth groups. There can be no doubt in the mind of him who has watched the course of mild and aggravated rachitis that the disorder is one of nutritional disturbance. Whether in these theories it has not often been necessary to make the etiology fit a series of symptoms, is a legitimate question. At all events, we know both by animal experimentation and the care of children in public service and private practice, that we have to deal with a disease that is directly caused by errors in feeding and here, if ever, true scientific investigation of the excretions, in fact experimental research of metabolism counts for something, and based on the findings of the relation of ingestion and excretion, it will be possible to find the food of greatest nutritional value for the individual case.

Of course, as in many other subjects of our profession, it is as yet impossible to close the chapter on these points. I have added nothing new; but in a symposium, such as this, where the nutrition of the first two years of life is being discussed, I think I have fulfilled my part in calling your attention, (1) to the facts, that while we know that cretinism is due to the congenital or postnatal hypothyroidism, that scorbutus is due to the lack of antiscorbutics in the tissue metabolism, and that in rachitis, we have to deal with a disease due

to errors in feeding, and possibly bacterial invasion; (2), that if we probe further for their ultimate causation, we enter a wilderness of doubts and contradictions, which will unfortunately remain so until both the physiology and pathology of digestion are settled beyond a doubt.

DIARRHOEA IN INFANCY AND EARLY LIFE.

By Irwin H. Hance, M. D., Lakewood, N. J.

In nature's workshop repair of injury constitutes her most powerful characteristic; associated with this, and equally powerful, is her effort to resist invasion of disease. Were we, as physicians, to heed more often the warning cries of threatening danger we would less frequently be called upon to treat the serious consequences of our omissions; in no class of cases is this more applicable than in the diarrhoeas of infancy and early childhood. In New York City the mortality from gastro-intestinal diseases in children under two years of age exceeds that of all of the five contagions—measles, scarlet fever, whooping cough, diphtheria and typhoid; consequently no subject is more worthy of our attention, and we should use every effort to prevent simple diarrhoeas from passing into a more serious and oftentimes fatal condition.

Diarrhoea is a symptom, not a disease *per se*; due to increased peristaltic action of the bowels, and always associated with a free discharge of fluids from the vessels of the intestinal canal. It is nature's effort to avert disease. It may, however, be the beginning of an acute toxic infection, an acute inflammatory process, or an infectious disease. Therefore, it behooves us to note the warning and avert the more serious consequences which so commonly and quickly follow; the younger the child the more urgent the call for immediate action, for with each successive year of life the child's resistance is materially strengthened.

In the beginning of an acute intestinal toxæmia the degree of the diarrhoea is no indication of the severity of the attack. The subjective symptoms are as follows: sudden invasion of disease; restlessness may be extreme, occasionally convulsions or coma; anorexia; vomiting may or may not be present, if present vomitus very sour and containing undigested food, and when persistent becomes bilious; rapid pulse; temperature usually pretty high; tongue furred;

breath heavy, at times foul; stomach and bowels distended with gas; abdominal tenderness, slight or absent; stools moderately frequent, offensive in character, containing undigested food, loose, at first yellow then green in appearance, and with small amount of mucus present.

Nearly all diarrhoeas are associated with varying degrees of toxic infection in its acute or chronic form, and the transition from a simple fermentative diarrhoea to an acute inflammation of the bowels is a very easy and often rapid one. The younger the child the more rapid the change and the more urgent the need of removing all causes which aggravate or cause a continuance of the inflammation. It is not my purpose to enter in detail into a description of the pathological processes which produce these inflammations; nor the location of the inflammation in the bowel. In general, we may look upon the earlier diarrhoea as the first indication of the inflammatory process. When gastro-enteritis or entero-colitis arises all the symptoms become more persistent and are intensified. We must always bear in mind that we are dealing with the greatest absorbent tract of the whole body and whether inflamed or not at the beginning it is sure to set in if the diarrhoea persists.

There exists, then, two causative factors which aggravate the condition: first, a mass of fermenting material in the lumen of the tube containing a toxin which not alone is dangerous itself, but acts as a local irritant to the mucous membrane; and second, an inflammation of the mucous membrane at different points in the ileum and colon. These two conditions with their diversified symptoms may be best illustrated in their extreme degree by the severe attacks of cholera infantum in infants or ileo-colitis with dysenteric symptoms in older children. In the light of our present knowledge, all diarrhoeas are due to an infection. We must bear in mind the possible presence of typhoid in persistent, prolonged cases of diarrhoeas.

Among the causative factors of diarrhoea the presence of other diseases must always be considered as in the so-called eliminative diarrhoeas. Foreign bodies and intestinal parasites as irritating causes must be thought of. Diarrhoeas of nervous origin are also commonly met with. The almost universal cause in infancy is the food, in older children in a large majority of all cases it is the feeding. To digestive disorders may therefore be attributed the large

percentage of all cases of diarrhoea from the ingestion of improper or bacteria-laden food. The frequency of feeding and the character of the food, as regards quality and quantity given, must ever be borne in mind. In infancy milk constitutes the only food during the first year of life, and whether breast or artificially fed the quality as regards the proportion of fats, proteids and sugars or the quantity, as in too frequent feedings, may cause the diarrhoea. Later on in life the variety of the food may be the direct cause.

The treatment of diarrhoeas is often the most difficult task presented to the physician, since the cause is due to improper feeding. The fundamental principles for treatment are individualization; find out what this infant or child will digest; be guided by the functional power of the stomach and bowels to digest and absorb food of a given strength and quantity, and not feed according to any rules laid down for the age of the child. Place the child under the best hygienic surroundings, where the maximum of light and fresh air are to be secured. Keep the child quiet, avoid all noises, too much fondling, and sometimes too much attention in nursing. Inspect the clothing of the child and dress properly, according to the season and temperature. Have child wear flannel abdominal binder until four years of age. Avoid chilling. Bathe child daily and see that the skin performs its normal functions. Give written instructions what strength of food to use.

A general routine procedure in simple or severe diarrhoea is to clean out thoroughly the alimentary canal, after which allow the functions of the stomach and bowels absolute rest for 24 to 36 hours, then begin with a very weak food and gradually work back to the normal food for the child. Always inspect every stool daily. In treatment the weightiest problem for our consideration is the matter of food. What forms the child's chief sustenance, and in the first year of life its only food—milk, may of itself become a poison and be the sole cause of an illness which rapidly transforms a healthy infant into a delicate one or causes death. In milk the proteids and fats are the most likely to produce indigestion, and success in treatment rests upon a careful study of the digestion of these two ingredients; this is true of breast fed infants, but more strikingly so in artificial feeding. Therefore, after a free purgative has been administered and twenty-four hours have elapsed,

during which time water may be given freely, begin a mixture of small percentage of fats and low proteids and work up slowly in the strength and quantity of milk, watching the stools for any reappearance of milk indigestion. Two or possibly three feedings of milk, along with wine whey and barley water, during the second 24 hours suffice. It is my universal custom to pasteurize all foods in such cases, not only in summer but also in winter; the milk mixtures should contain also lime water and barley water; sugar of milk be used instead of cane sugar. Concerning the frequency of feeding never oftener than every 3 hours, to begin with every four. When the first preparation agrees with the child and is thoroughly digested use the second stronger mixture every alternate feeding for 24 hours, always keeping on hand a half day's supply of old mixture until it is certain that the new mixture does not disagree with the child.

Reliance on drugs to cure the condition is putting one's faith on a shattered reed. In my practice four drugs constitute my armamentarium, and in the following order: Calomel in small doses at hourly intervals until $1\frac{1}{2}$ to 2 grains are taken; castor oil in full doses, repeated without any hesitancy during the attack; bismuth subcarbonate in large doses, given most conveniently in the old time chalk mixture; opium in the form of paregoric when the frequency of the stools, or their too watery consistency, forms an indication for checking somewhat the peristaltic action. A few years back rectal irrigation at stated intervals was a routine procedure; to-day it is properly used only occasionally and is of great value. The normal salt solution at a temperature of 90° to 95° F. is the best solution to use, for thereby a large quantity of water is absorbed into the blood vessels.

Preventive measures must rest chiefly on the methods of feeding infants and children and a suitable milk supply. This has been clearly proven in New York City by the great diminution in the mortality from diarrhoeal diseases in children under five years of age since the Straus depots for modified and pure milk have been in active operation. The education of the mother to use modified milk and not to rely on proprietary foods will save many lives. In my own practice among the working class each year I have been able to convince several mothers that modified milk properly prepared and regularly given is the simplest

and best way of artificially feeding their babies. Instruct the mothers concerning the dangers of a simple diarrhoea, especially during the summer months, and not to delay in sending for their physician. Of supreme importance is it to secure a pure milk, unadulterated with water, containing no preservatives and free from pathogenic germs.

The scientific study of the ingredients of mother's and cow's milk has at all times interested many physicians; the proper modification of cow's milk has been carefully worked out on a scientific basis by Rotch, Holt, Winters, Chapin and others. A careful study of their works has been of inestimable value to me and the results attained from following their advice has widened my experience and saved the lives of many children.

In a broad general manner it has been my object to present to you this paper in the hope that it will elicit a discussion which may add to our experience in treatment and to our knowledge of how best to prevent a condition which causes so many fatalities in all sections of our country.

DISCUSSION

of the Papers on Symposium on Nutrition and Dr. Hance's Paper.

Dr. David E. English, of Millburn.—It seems to me that Dr. Coit's paper comes about as near being a perfect paper on this subject as human limitations admit. I am pleased at the broad ground he took. I think that sometimes we forget or ignore the fact that there is something else which has to do with the digestion in infants besides the composition of the infant's food. The very fact that there has been so much study, work and investigation on making a perfect infant food suggests the question whether in our efforts to make a food fit for the digestive organs of the infant, we neglect the digestive organs of the infant, neglect to make them fit for the food. The baby cannot digest the best mother's milk well and thrive on it if not properly taken care of. The baby will not be healthy and happy unless it earns its living. The first mistake usually made in infant feeding is the manner of feeding. I do not believe that the infant's digestive organs can always digest the same amount of the same kind of food in the same number of minutes. Therefore, I do not believe in regular feeding. I think the old fashioned method feeding was about as bad as could be.—when the baby cries, feed it a little. The scientific feeding following this was a great improvement, but I think there is still room for improvement. Do not feed the baby until it is necessary to do so and not until the baby's stomach is empty. My instructions are not to feed the baby until the mother cannot stand it any longer. The baby can stand it better than the mother. When the baby's stomach is empty, and after a time of rest, when it has thoroughly contracted and resumed its tone, then is the time to

feed the baby. Then feed it until it is full. You cannot develop the baby's organs of digestion unless you exercise them to the limit. If you allow sufficient time for digestion, evacuation, contraction and rest, dilatation will not occur; dilatation is caused by feeding too frequently. A little food left in the stomach is a hotbed for the germs of fermentation, and fresh food introduced into the stomach before it has become entirely empty soon ferments, and it is in this way that dilatation is caused.

One of the most important things about a baby in getting it to properly digest its food is to give it exercise enough. I am a believer in the air bath. Place the baby, without any clothing, upon a moderately firm surface and it is surprising to see how much exercise it will get, and how much it will do to earn its living.

Dr. Richard Cole Newton, of Montclair.

I should like to say a few words about lactation. If we look at cows we find they give a highly specialized milk, and they give four or five times more milk than their calves can advantageously take. If the calf sucks its dam it is getting a kind of modified food and will not flourish on it. Dairy cattle are a race of animals quite different from the wild cow. The udders of the latter are smaller than those of the domesticated animals. The milk they produce varies in quantity and in quality from the milk we get from the dairy. Tuberculosis is said to be unknown in wild cattle. Practically the lesson to be learned by analogy is that our women attempt too many things. The cow does not attempt to do anything except produce milk; it leads a contemplative life. Dr. Brush, of Mount Vernon, has said that one cross man in the dairy would do more harm to milk than would have resulted from feeding the cows distillery swill. So sensitive are calves and lambs to milk that has been effected by nervous shock to the mother that they have died just because the dam has been frightened. Milk is a highly specialized product; it is a highly complex substance, the true nature of which is as yet little understood. Pawlow has recently discovered properties in milk which were never dreamed of before. It seems to me that the time has come when the physical life of women should be made such that they can nourish their own children. Feeding modified milk is only a crutch. Take a lesson from our friends, the cows, and have the women keep away from clubs and afternoon teas and from all excitement and over-exertion when they are nursing their young. There is a moral side to this question of the failure of modern women as nurses, which needs careful study. Dire and lasting disaster awaits our race if the women can not nourish their children.

Dr. J. Finley Bell, of Englewood.—I agree in the main with what has been said. For some years I have been in the habit of administering small doses of podophyllin instead of calomel and soda, I do not know why except that I get better results in certain cases.

In reference to the examination of the urine in cases of diarrhoea, I think it is very well to examine the urine in every intractable case for albumin and casts. Many protracted cases of illness, accompanying or following diarrhoea are caused by nephritis; otherwise they would be unobserved.

With reference to Dr. English's remarks I

think it should be borne in mind that the object of pediatricians, and those interested in rational infantile dietetics, is not to make a perfect food to agree with all children, but, by a more intimate knowledge of the chemistry and biology of milk on the one hand with the physiology of the infantile digestion on the other, to make a rational adaptation in each particular case. I do not think that anybody is interested in making a ready-made infant food to be used in any and all cases.

With regard to the method of feeding, I can only say that I believe, and experience has borne out the fact, that irregular feeding will not only ruin the child's digestion, but also the mother's milk supply.

Dr. John Deland, of Philadelphia—I have had no experience in the diarrhoeas of infants, but I have had in children of five or six years and older, and it has been that toxins are the cause of these diarrhoeas. I take it, this is one of the most important advances in this subject, comparing it with the advance made in earlier years. It occurred to me that a few words on this subject would not be amiss. The closest scrutiny of the discharge should be made and some plan of procedure should be employed in all cases to recognize certain elements, such as indican in the urine. The habit should be formed and maintained of examining the urine for the presence of indican. In administering treatment to which reference has been made, it seems to me oftentimes it might be necessary, if large quantities of indican are present, to give the evacuation treatment. The relationship of indicanuria, indicating the chemical changes going on in the intestines, and the toxæmia is extremely important. Colonic lavage is a very important method of treatment in certain cases, but with the difference as regards application—I use it at a temperature of 104; when it enters the colon it has been reduced to about 100. This method of treatment has a number of advantages. In the first place it removes from the colon materials which may be the source of supplying the toxic material. In giving these colonic lavages frequently a notable quantity is retained, more in the region of the caecum and ascending colon, and this is absorbed, so tending to supply the tissues with what they need.

Dr. William H. Walling, of Atlantic City.—I have used the arsenite of copper with great success in the diarrhoea of infants, and I should like to ask if any here have made use of the drug in this and kindred disorders.

Dr. Irwin H. Hance, of Lakewood.—With reference to acute intestinal toxæmia, that was left out of my paper purposely, as well as the question of rashes. When these rashes appear I am frequently called in to decide whether or not the cases should be quarantined. It often is very difficult to state whether they belong to the exanthematous group or not. These two things were not mentioned in my paper because they were only occasionally met with, and in most cases there is no diarrhoea. I have never used arsenite of copper in the treatment of diarrhoeas in children.

When a patient complains of dysphagia, do not neglect to examine the pericardium for effusion.—*Amer. Jour. of Surgery.*

Clinical Department.

REPORT OF A CASE OF RABIES.

By Henry V. Davis, M. D., North Branch, N. J.

The patient was a boy aged 10 years, of good health and parentage; had been bitten by a dog on the 6th of June; there were several punctured wounds on right fore-arm, which were cauterized ten hours later; a wet bichloride dressing was kept on and healing took place in the usual manner. I was again called to see him on the morning of 4th of July. He had been unwell the previous day with restlessness and loss of appetite. I found him with temperature 100° F., pulse 112 and complaining of pain beneath lower ribs on right side. Examination was negative. I put on two adhesive straps which did not relieve pain; eyes were somewhat staring, pupils were dilated; face did not have a natural appearance. I saw him again the following day, the 5th, at 9 A. M., temperature 100.5° F.; pulse 120; had been restless and sleepless during the night; still complained of the pain in side. (This pain was probably reflex from the spine); same facial expression, only more pronounced; was nervous and excited; on touching his side for examination would wince—showing hyperæsthesia. His mother stated that on the previous afternoon, about 5 o'clock, she noticed a choking on swallowing water. I ordered a drink of water for him, he took it, but on swallowing, a spasm of the throat took place which excited him very much, at the same time he would place his hand on his throat. As the boy had been bitten by a dog a month previous, rabies was suspected. He was taken to the Pasteur Institute, New York, for further examination and advice. He was there examined by Dr. Wheeler, who soon diagnosed the case as rabies, and said that there was absolutely no hope for him, and that he would die the following afternoon, (this being about noon of Thursday, the 5th). An interesting feature of the examination was made by Dr. Wheeler's blowing a puff of air in the patient's face which brought on a spasm of the muscles of respiration and deglutition, the boy at the same time grasping the region with his hand. Dr. Wheeler stated to me that this was pathognomonic of rabies and was not manifested in any other disease.

The boy made the trip very well. It was observed that when sitting by an open window in the car that a strong draft of air striking him would bring on a similar spasm and cause him to shrink in fear, at the same time putting his hand to his throat and chest. He wore a white brimmed hat which he would draw over his face as a protection from the wind. He was subsequently moved to a more secluded place. He was inclined to talk on the trip, observing many things. In the doctor's waiting-room a glass of water sat on the table, from which he took a drink of his own volition, but it agitated him, bringing on a spasm as usual. Having occasion to walk a block or two he soon became tired and his gait was somewhat ataxic. On arriving home in the evening he was tired, drank some warm milk, which he swallowed without much difficulty, and went to bed. His condition became more serious during the night; he did not sleep, and there were almost continued movements of arms and much random talk. He

could swallow during the night and had taken several doses of a mixture of bromide and cicutine. I saw him again on the morning of the 6th, his temperature was 102° F., pulse rapid and weak. The secretion of saliva had increased, which became frothy about 5 A. M., forming on his lips from the constant movements of his tongue. He talked much during the day, imagination was lively, with hallucinations at times. Had refused all food or drink since the previous night, the mere suggestion of either greatly agitated him, noises or running water did not disturb him. There were no general convulsions.

The second or paroxysmal stage lasted two days, the emaciation was marked, the pulse gradually weakened. About 4 P. M. Friday the paralytic stage became evident, talking and movements ceased, lapsing into unconsciousness three hours before death, which occurred at 8 P. M. The total duration of the disease was three and one-half days. The dog, a small black and white one, came on the playground at school, the boy attempted to fondle it and was bitten. The dog did not attack any of the other children, but went off. The boy assured his playmates that he knew the dog and it belonged to a neighbor and was all right. He was probably mistaken as to its being a neighbor's dog, as it was learned by later inquiries that a wandering dog was shot soon after in an adjoining neighborhood.

SOMERSET COUNTY, Dr. C. R. P. Fisher, Reporter.

The regular quarterly meeting of the Somerset County Medical Society was held at the Ten Eyck House, in Somerville, on July 12th, with a good attendance of members. Dr. Hammill, medical director of the Prudential Life Insurance Company, was present, and made a statement on the "Medical Examiner's Fee Question from the County's Standpoint," and a resolution was passed indorsing the action of the Medical Society of New Jersey in the matter, and a copy of the resolution was ordered sent to every physician in Somerset county. All the members present took part in a discussion on the "Gastro-intestinal Diseases of Children."

Dr. H. V. Davis, of North Branch, reported a very interesting case of rabies which had recently occurred in his practice. I send you his report for publication.

Congress for the Repression of Illegal Practice of Medicine.

—It met in Paris, France, May 28, 1906, with 300 physicians in attendance. Prof. Brouardel opened the session. The ministers of public instruction and of the interior and the prefect of police were also present, and several lawyers were among the speakers. Special emphasis was laid by many of the speakers on the necessity for collecting all the cases of injury from quack practices that are known. Each local medical society was urged to have its members on the alert for such occurrences. Among the resolutions adopted was one to the effect that the medical syndicates should coöperate in the production of a work showing the danger and damage from irregular practices and ask that the subject should be presented in the schools. Other resolutions were adopted advocating the restriction of massage, and urging that massage should be taught in the medical colleges. Levassort urged the organization of a central office, to be supported

by contributions from the various medical societies throughout the country, the official title to be the Central Office for the Protection of the Public Health Against the Illegal Practice of Medicine, which office should centralize the efforts of physicians in the repression of quackery, and the education of the public; collect and classify data in regard to illegal practices and supply information. The suggestion was on motion adopted, as was another offered by the same speaker, for the collection of data for an official directory of all the legally qualified practitioners of medicine in France. The education of the public was specially emphasized as essential to success in the suppression of quackery.

PRIZE ESSAY.

This prize was instituted by the Medical Society of New Jersey at the annual meeting in 1905, and is open for competition to the members of the Component (County) Medical Societies.

The subject chosen is "The Symptoms, Etiology, Pathology and Treatment of Pneumonia."

The essays must be signed with an assumed name and have a motto, both of which shall be enclosed in a sealed envelope containing the author's name, residence and component society.

The essay shall contain not more than 4,000 words, and must be characterized by originality in investigation and thought, and by clearness and conciseness of expression, and be, in the judgment of the committee, of decided value to the members of this society, and to the profession generally. Failing in these respects, no award will be made.

The essays, which should be type-written, with the sealed envelope, must be placed in the hands of the committee on or before the first day of May, 1907.

The committee will select the first two essays in order of merit. To the first will be awarded the prize of one hundred dollars, to the second that of honorary mention.

The unsuccessful authors will receive back their essays upon their identification to the chairman of the committee. The successful essay will be the property of the society and be published in its transactions.

CHARLES J. KIPP, Newark, *Chairman.*

WALTER B. JOHNSON, Paterson.

DAVID C. ENGLISH, New Brunswick.

Committee.

In cases of head traumata, bleeding from the mouth or nose does not necessarily mean that the case is one of fracture at the base. The hemorrhage may be entirely due to a localized injury. —*Amer. Jour. of Surgery.*

THE JOURNAL

OF THE

Medical Society of New Jersey.

SEPTEMBER, 1906.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any one failing to get the paper promptly will confer a favor upon the Publication Committee by notifying them of the fact.

All communications relating to the JOURNAL should be addressed to the Committee on Publication, 95 Essex avenue, Orange, N. J.

DOES THE MEDICAL PROFESSION NEED PROTECTION?

We have in another column emphasized the point that the welfare of the public should be the plea in all our society's efforts to secure wise legislation and to prevent the enactment of pernicious laws affecting the health and lives of our citizens, and that the argument should never be for the protection or advantage of the medical profession, and especially regarding legislation for the prevention of the illegal practice of medicine, or for legalizing unscientific and harmful methods of treating disease. It will be seen in the article, printed on another page, on the Congress for the Repression of Illegal Practice of Medicine, held in Paris, France, May, 1906, that the action taken was "*for the Protection of the Public Health against the Illegal Practice of Medicine.*"

We do not mean that the medical profession needs *no* protection, for it certainly is not permitted to enjoy all the rights and privileges which its exalted and beneficent position warrants, nor is it held in the high esteem by the public which, as a profession, it is entitled to receive. It requires no argument to prove that the respect, amounting almost to reverence in former days, for its members, who exerted a very decided influence in the home, in the community, in our courts of justice and elsewhere, has been sadly lowered to the great detriment of the profession and to the far greater dam-

age to the family and the community, not only as affecting existing disease conditions, but also social customs and conditions and educational methods as they affect the moral, mental and physical welfare of the present and future generations.

The profession needs not, however, the protection that comes from without, but that which works from within its ranks—self-protection and the protection of the fellow members of our profession. Its efficient method of work is through thorough *organization*. An organization that shall seek earnestly and persistently, as among the things essential to the highest success, the following:

The enrollment of every educationally qualified practitioner; the restoring of the *esprit de corps* of the profession; the putting away of petty jealousies; the strict observance of ethical relations with each other; the doing away with contract work for societies and corporations controlled by men whose respect for their medical employees soon becomes commensurate with their compensation; the increasing scientific attainments and influence of its members, and the more conscientious care in giving testimony, especially expert medical testimony, in our courts—testimony that shall serve the ends of truth and right rather than the parties in whose behalf we are summoned to testify.

Excepting the clerical, there is no more exalted and honorable calling on earth than that of the medical profession, because there is none more serviceable to humanity, not only in the relief of suffering and the cure of disease, thereby saving human life; but also in the nobler work—because it is more unselfish and of far greater value to the individual and the State, of the prevention of disease; and also in its charities bestowed so liberally that it is often abused by the undeserving and well-to-do in private practice, hospitals, dispensaries, &c. Of such a profession he is a worthy member who respects himself and has a proper respect for the dignity of his profession, acting the gentleman—ethical in his relations with his

fellow members, seeking to be serviceable to his fellow men as a physician and a citizen, striving not so much to get ahead of his fellows but to get ahead of himself—a better, truer, more scientific physician this year than he was last year. Such a man would zealously guard the honor of his profession and the standing of his medical brethren, and a profession composed of such men would command the respect of the community and the State; its influence would be mighty in our legislative halls, it would control all legislation affecting the public health and the medical profession.

As we look toward the future, it is with no pessimistic forebodings. *Organization* is the watchword of the hour and it means advance—the getting together of the profession, the doing away with old prejudices, one body united of educationally qualified physicians seeking after fuller knowledge of scientific truth and the best way to apply it in the relief of suffering humanity and the prevention of avoidable disease. The American Medical Association is leading the way. The last annual meeting of the Medical Society of New Jersey gave evidence that our members are awake to the situation and are getting ready for action. That action, however, must begin in and be carried on largely by our county and city societies by thorough organization and efficient work in unifying the profession and increasing the scientific attainments of its members through carefully planned and successfully carried out programmes for their meetings. The programme should include at least one paper on some professional subject, which should be previously announced, and the presentation of clinical cases, if possible, and more time than is usually given should be allowed for discussion of these subjects or cases. The meetings should be far more largely attended and each member should be encouraged to contribute toward the interest and profit of the meetings. Let us *thus protect*, advance and exalt our profession that it may occupy and ever maintain its proper place among the learned professions.

THE OFFICIAL STATE JOURNAL VS. THE INDEPENDENT MEDICAL JOURNAL.

The August number of *Critic and Guide* contained an able paper by its editor, Dr. W. J. Robinson, of New York, on "The Official State Journal vs. The Independent Medical Journal," which was read before the American Medical Editors' Association, at Boston, June 4, 1906. The doctor deserves credit for handling his subject in a plain, courageous way, considering his audience, though it is evident from the opening paragraph that he appreciated the delicacy of sharply criticising some of his hearers' work. The writer's views are first given on the objections to the official State Journal, briefly stated, they are as follows: (1) The management is apt to be in the hands of those who happen to belong to the machine, men not the most capable or most fitted for the work, and the editor the one with the biggest pull; (2) the lack of responsibility, or of obligation to the readers, the managers and editor feeling no obligation to make particular efforts in order to give a really excellent journal; (3) it is not calculated to furnish favorable soil for the growth and development of independent medical opinion, of independent and iconoclastic thought; rather the opinions of a clique or dominant few, or of the powers that be; (4) it prints all the papers and discussions read at the various meetings, much inferior "stuff" occupying pages and pages of our State Journals. The strong point of the State Journal is then dwelt upon at some length, viz: its absolute financial independence which enables it to keep the advertising pages absolutely clean from all fraudulent advertisements. He says: "It is decidedly improper, unseemly and unfair for an official medical journal to send out advertising agents and engage in scrambles for advertising patronage. It is most decidedly, most emphatically not the province of an official journal to make money."

The writer then considers the private journals, contending that many so-called medical journals are a libel on the name of

Journalism, not only referring to their advertising, but also to their reading pages, such, he says, "have no right to live, and the sooner they die, the better. * * They are not published for the purpose of disseminating truth, or because the editor has a message to give the world—they are published for the purpose of making money for the editor and publishers." We have given a very brief outline, which we realize fails to do full justice to the author in stating the points made by him. We endorse in the main his views and hold that the objections are well taken where the conditions described exist, and we are in full accord with him when he says: "It is the province of an official journal to spread scientific knowledge, to give information about the happenings among the profession of the State, to fight quackery and charlatanry in and out of the profession, to look out for our interests in the Legislature; and that is all. It may carry a few announcements of books, colleges, sanitariums, surgical appliances, etc., but I repeat it is not proper for a great medical society to publish its official journal on the money obtained from manufacturers, money usually obtained under pressure—the pressure being the prestige of the official journal and the good will of the profession of the State."

We take only one exception to these remarks: "to look out for *our* interests in the Legislature," for we maintain that the medical profession, in New Jersey at least, asks no protection or favors and needs none from the Legislature save such as our Society's charter provides. Our State Society has not made, and the *Journal* will not endorse any effort in that direction. The society has ever acted, and the *Journal* will ever be true to her past traditions—in seeking from the Legislature only such legislation as is believed to be conducive to the public welfare, and opposing such as is sincerely believed to be inimical to the highest interests of the people. But in discussing the subject of Dr. Robinson's paper, we would say at the outset that we do not consider the official *State Journal* and the

Independent Medical Journal as antagonistic the one to the other. Each has its sphere and there are very few physicians who receive the former who are not also subscribers to one or more of the latter, but it is a good sign that they are more discriminating than formerly in their selection of the latter. The *State Journal*, let us remember, then, in discussing its merits and demerits, is not a substitute for the *Independent Journal*, it is distinctly a *State* publication which has in most, if not in all, cases taken the place of the old volume of "Transactions," issued usually from three to six months after the annual meeting, and which contained all the proceedings,—papers read and discussions thereon, reports, &c., &c. We think that in most cases this volume when received by the members was hastily scanned and placed on the shelf as a reference book; its papers, scientific or pseudo-scientific, seldom being read. The *Journal*, on the other hand, comes monthly, gives not only all that the one volume contained, but much additional matter, which tends to make it a thing of life and influence. We need not here restate its other obvious advantages.

As to our own *Journal*, the announcements of the committee on publication and the editor, in our August issue, indicate that it is our desire and purpose to keep the *Journal* free from the objections specified in the paper under consideration. It may be questionable whether all the papers read at the annual meeting of the State Society, and those read before the county societies, are carefully prepared and show decided value from the literary or scientific viewpoint. Some perhaps are too lengthy, going too much into detail in unimportant matters that are more tersely expressed in our text books; some may be faulty in expression and grammar, showing carelessness, while some authors do not seem to realize that to be accurate is scientific and to be inaccurate is unscientific. But we cannot discriminate in a State society journal, giving the proceedings of its annual meeting as closely as the so-called Independent journal might do.

If criticism is made should it not affect the careless writer rather than the journal which must be impartial and somewhat liberal? The editor may correct the errors in grammar and generally the otherwise faulty expressions, but he should be spared the work of abridging papers and correcting the inaccuracies in the writer's investigations, statements of facts and the deductions drawn therefrom.

The wheat must be separated from the chaff in all journals, both as found in the papers and editorials admitted therein. We shall strive to make our *Journal* generally acceptable to the members of the profession in New Jersey, for whom chiefly it is issued and to whom we are accountable. We are not indifferent concerning the good opinion of our sister State or other journals or of the profession beyond our State. We recognize their good work and appreciate their kind words of congratulation and commendation; their criticism we shall doubtless merit for we lay no claim to infallibility. We know "tis human to err" and we are inclined to agree with the *Critic and Guide*, that "it is better to make a mistake in trying to tell the truth, than never to tell the truth for fear of making a mistake."

THE NEW YORK CITY GARBAGE.

We regret exceedingly that the confidence we expressed in our August issue of the *JOURNAL*, concerning the prompt correction by the New York authorities of the defilement of the bathing beaches of our sea coast by the garbage from New York City, seems to have been misplaced; at least the promptness appears to have been in the promises made, while the fulfilment tarried so long and the nuisance became so intolerable that Gov. Stokes felt compelled to personally present the facts to Acting Mayor McGowan. The Governor presented them so tactfully and forcefully that we believe New Jersey will now receive the relief which it has a right to demand. The *Newark Evening News* in an editorial well says:

"New York's latest promises are so full

and so seemingly fair that they will be once more taken at their face value until they are found to be below par. Acting Mayor McGowan has already ordered the scows twenty-five miles off shore; and if that doesn't prove effective he'll send them fifty miles away, and even farther if necessary. There is, he explained, an inspector on each boat, and the contractors will not get paid if they do not go beyond the stake-boat that indicates the nearest dumping limit. 'We are not,' the Acting Mayor concluded, 'going to quarrel with the people of New Jersey; we think too much of their good opinion.' * * * New Jersey wants to be in every way friendly to New York, but when the greatest and wealthiest city of the Western World, with the illimitable ocean as its disposal works, practically makes New Jersey its dumping ground, this State becomes intolerant of such treatment."

We were sorry to see in one of the New York City newspapers, which we have for many years esteemed as one of the best and fairest dailies published, the following editorial brief:

"We must sympathize with the Jersey-men who object to having New York garbage washed up on their beach. We hope that they will appreciate the feelings of New Yorkers who object to having the sewage of great New Jersey cities poured wholesale into the narrow waters of this State and city."

We submit that "you're another" is not the best kind of an argument, especially when it lacks force from inaccuracy of statement. It has been estimated that there is now discharged into the upper New York bay and the Hudson and East Rivers from the city of New York and the municipalities of Hudson county about 500,000,000 gallons of sewage per day, and yet analyses made a year or two ago (the latest we have at hand) showed that the water in the channel of the Hudson river and New York bay was purer than that of the Hudson at Poughkeepsie, where it was proposed at that time to secure a pumped and filtered water supply for

New York. We shall not enter into a discussion of the agencies of purification at work on this vast amount of sewage, which tend to prevent damage to us and our neighbors, but will only state them as follows:

First, dilution by salt water; second, chemical action, viz.: (a) the oxygenation of the organic constituents by the dissolved oxygen in the water, and bacterial action; (b) the precipitation of certain constituents of the sewage by the salts contained in the sea water; third, the consumption of the organic matter in the sewage, as food, by the marine life with which the water teems, and also by bacterial action; fourth, transportation from the points of discharge into the ocean by the tidal currents.

We quoted in an editorial in the August JOURNAL the judgment expressed by the late Civil Engineer Croes, who was one of New York's ablest engineers—That the discharge of the entire New Jersey sewage in the manner proposed by the New Jersey State Sewerage Commission for the sewage of the Passaic Valley, would be less liable to produce unwholesome conditions along the shores of New Jersey, New York and Staten Island than would be the discharge of the same in Newark bay and the Kills. We emphasize the remarks made in the closing paragraph of our former editorial concerning New Jersey's care in safeguarding the citizens of New York as well as her own people.

We are pleased to hear that Civil Engineer Hazen, of Paterson, has approved the method of sewage disposal recommended by the State Commission and that Gov. Stokes will probably convene the Legislature in special session in order that laws may be enacted that will facilitate the completion of this greatly needed work.

We hope that the County Societies' Reporters and Secretaries have been enjoying their vacations during August. Somerset's Reporter only has been heard from during the month.

Members of the Society who desire to have their monthly JOURNALS bound can ascertain the rates and where to send them in the advertisement on page III of this JOURNAL. Prompt action is desirable, especially by those who desire to be supplied with missing numbers of the JOURNAL.

Book Review.

THE INTERNATIONAL MEDICAL ANNUAL.

A Year Book of Treatment and Practitioner's Index; 32 contributors. Twenty-fourth Year, 1906.

New York. E. B. Treat & Co.

8vo., cloth; 588 pp.; \$3.00.

This volume is similar in arrangement, size and general make up to its predecessor of last year, although it contains 56 less pages. The general excellence of the matter in this book and the concise manner of its presentation will maintain the high reputation which the annual has long had. We know of no publication that contains so much information in so compact and accessible a form as this one. While most of the contributors are Englishmen, there seems to have been a thorough overhauling of American as well as all other periodical literature for the years 1904 and 1905. The illustrations, as usual in the *Annual*, are good and there is the usual excellent and complete index as well as the references to the literature at the end of each separate article. We especially commend the practice of the contributors of signing their full names to their contributions. There is the usual short article on general hygiene and sanitation at the end of the book, and the "list of the principal medical works published during the year 1905, chiefly American." R. C. N.

"OPERATIVE OTOTOLOGY, SURGICAL PATHOLOGY AND TREATMENT OF DISEASES OF THE EAR.

By Clarence John Blake, M. D., Professor of Otology in Harvard University, and Henry Attridge Reik, M. D., Associate in Ophthalmology and Otology in Johns Hopkins University.

New York and London. D. Appleton & Co.

8vo., cloth; 359 pages. Price, \$3.50. 1906.

This book presents in an attractive and condensed form the results of wide experience and painstaking research. The style is simple and direct, and, while the operative technic is given with detail, so that the specialist may learn from the description the most approved modern methods of operating, so plain and distinct is the language of the text that the general practitioner or the student may understand it. As a working manual, a handy book of reference, this one is certainly worthy of high commendation. There is, moreover, through it all a moderation of state-

ment and a clearness of reasoning that are quite satisfactory.

The book proper is divided into eight chapters: Surgical anatomy of the temporal bone and adenexia; aseptic technique; diseases of the auricle and external auditory canal; diseases of the tympanic membrane and tympanum; the possible complications and consequences of suppurative otitis media; middle ear operations; mastoid operations; adventitious aural surgery (adenoids). In this chapter various operations subsidiary to aural surgery are briefly described and their indications pointed out. They are: Adenoidectomy, subcutaneous and intravenous infusions and lumbar puncture.

An appendix, consisting of eight short articles, or "notes," follows the main portion of the work, and adds distinctly to its value. The typography, paper and binding are of the best, and there is a good index. We do not hesitate to commend the book.

R. C. N.

Personal.

Dr. Maxwell S. Simpson, of Middle Valley, who was seriously injured in a runaway accident, we are pleased to hear is gradually recovering. **Dr. A. L. Stillwell**, of Somerville, has been elected President of the local Board of Health. **Dr. Louis C. Williams**, of Lambertville, is in Canada for his vacation. **Dr. B. B. Ranson**, of Maplewood, is spending his vacation in Nova Scotia. **Dr. H. S. Wheeler**, of Whippany, is at Bretton Woods, N. H. **Dr. R. B. Freeman**, of South Orange, has returned from a season of rest on Long Island. **Dr. Anna B. Newton**, of South Orange, will spend September at Fairlee, Vt. **Dr. R. P. Francis**, of Montclair, is spending his vacation at Good Grounds, L. I. **Dr. G. L. Romine**, of Lambertville, has returned from Watkins Glen, N. Y. **Dr. J. T. Wyckoff**, of Leonia, was registered at Sea Girt, and **Dr. Paul T. Kimball**, of Lakewood, at the New Month-mouth House, Spring Lake. **Dr. Ralph Opdyke**, of Montclair, expects to join his family at Cape Elizabeth, Maine, early in September. **Dr. Joseph Fewsmith**, of Newark, is spending the summer at Newfoundland, N. J. **Dr. Charles J. Kipp**, of Newark, is spending a two weeks' vacation at Saratoga Springs. **Dr. Talbot R. Chambers**, of Jersey City, rested during August at South Dartmouth, Mass. **Dr. Stephen Pierson**, of Morristown, has gone to California for his vacation trip.

NEW MEMBERS OF THE AMERICAN MEDICAL ASSOCIATION FROM NEW JERSEY: **William S. Collier**, Trenton; **Henry P. Epstein**, Newark; **Benjamin S. Van Dyke**, East Orange.

Obituary.

Bartles—In Flemington, N. J., July 18, 1906, Dr. William H. Bartles, aged 63 years.

Bemiss—In Newark, N. J., July 11, 1906, Dr. Ezra D. Bemiss, aged 43 years.

Crouse—In Neshanic, N. J., June 29, 1906, Dr. Henry J. Crouse, aged 52 years.

Holmes—In Cranbury, N. J., August 21, 1906, Dr. John C. Holmes, aged 65 years.

Dr. A. E. Russell reports in the *Lancet* (Sept. 23, 1905), on the treatment of tetanus by spinal anaesthesia. A case of tetanus was successfully treated thereby. Sixteen c. c. of cerebral fluid were withdrawn and 3 c. c. of the following solution injected: 1½ grains of beta-eucaine, ½ grain of morphin sulphate and 3 grains of sodium chlorid, with sufficient water to make 3½ ounces. This procedure was repeated four times.—*Journal of the Amer. Med. Asso.*

Prof. A. L. Benedict, of Buffalo, writes in the *Medical Times*, June, 1906:

"There is a point in ethics, from the side of the manufacturer, which we have not seen mentioned in the literature. When a reputable firm places before the profession a really valuable article, either as a product of costly experiment or as a matter of ordinary business enterprise, and it is imitated without improvement by other firms, it seems to us plain that the profit should accrue to the original producer and that competing firms should be frankly told that the benefits of trade do not belong to them."

Physicians in Politics.—The *Semaine Médicale*, of Paris, comments on the exceptionally large representation of the medical profession in the French parliament, saying that it is out of proportion to the population, and to other professions. It says also that experience has shown that when a physician is elected to the national legislature in France he seems to lose all concern for the material interests of the profession and even for everything connected with medicine. It adds that it could cite the names of several confrères, long subscribers to the *Semaine Médicale*, who say they no longer have leisure to read it, as their time is so occupied with their legislative duties. France suffers very much from irregular practices and quacks of all kinds, even to the extent of having an irregular "School of Massage and Magnetism," conducted by one Durville, officially sanctioned by the state, and duly registered.—*Journal A. M. A.*

The JOURNAL will be glad to print original papers from any source, preferably from members of the State Society, provided that they shall be of sufficient merit and shall be contributed to this paper exclusively.

Anonymous communications will not be published, but the name of the author of a communication will be kept secret if the editor is requested to do so.

The Medical Society of New Jersey does not hold itself responsible for the sentiments expressed by the authors of papers.

It will be satisfactory to all concerned if authors will have their contributions typewritten before submitting them for publication. The expense is small to the author—the satisfaction is great to the editor and printer. We cannot promise to return unused manuscript.

Authors may obtain reprints of their papers at cost, provided a request for them be written on the manuscript. Matter received after the 20th of any month cannot appear in the next issue of the JOURNAL.

THE JOURNAL

OF THE

Medical Society of New Jersey.

Vol. III., No. 3.

Orange, N. J., September, 1906.

SUBSCRIPTION, \$2.00 PER YEAR.

OFFICIAL TRANSACTIONS.

Minutes of the Proceedings of the Medical
Society of New Jersey at its 140th
Annual Meeting, held at the
Hotel Chelsea, Atlantic
City, June 19, 20
and 21, 1906.

Tuesday Morning, June 19.

MEETING OF THE HOUSE OF DELEGATES.

The House of Delegates was called to order at 11.35 by the First Vice-President, Dr. Alexander Marcy, Jr., of Riverton, with the following remarks:

Gentlemen of the Medical Society of New Jersey:

It is unnecessary for me to tell you why I am to preside over this meeting. That it is an honor, as well as a pleasure to preside over the Medical Society of New Jersey, all of you will admit, and yet I cannot help feeling that the pleasure for me at this time, is not unmingled with sorrow.

You are all aware of the sad and trying circumstances which make it necessary for me to occupy the chair at this time. Our President has been incapacitated by illness, and he is not only unable to be here, but he is unable to appreciate the fact that the society is meeting in annual session at this time. Is it not pathetic to think that one so distinguished as was Henry W. Elmer, and who so richly deserved the honors which you conferred upon him, should be stricken with disease, so soon after being made Third Vice-President, and not now be able to enjoy them? In honoring Dr. Elmer, however, you honored yourselves as well, and we who know him best can best appreciate the truth of this statement. Perhaps few men in this society were more deserving, and few have done more to advance its interests.

Graduating from the University of Pennsylvania in 1869, just 100 years after his great grandfather had graduated from the same institution, he spent a year in Blockly Hospital, and then began his practice at Bridgeton. He joined the Cumberland County Medical Society at this time, and was always an active and influential member of it. For ten years he was the chairman of the "Standing Committee" of this society, and most

of you will recall his charming reports of the condition of the county societies as well as the condition of the profession as a whole. He was an unusual man in many respects—gifted beyond most of us, a typical example of what a physician should be; noble, high-minded, tender and true; beloved by his patients, honored by his associates, respected by the community in which he lived. Great as is the loss to this society, gentlemen, greater still is the loss to his intimate friends.

May I also say a word regarding my friend and co-worker, Dr. Taylor. It was his mantle that fell on my shoulders, and I am realizing more and more how difficult it will be for me to fill his place. He also was a man of many noble attributes, splendid character and charming and engaging manners. He served his county society faithfully for years, as its secretary, and although he had not been as active in this society as had Dr. Elmer, yet his influence was felt here on many occasions. Among his patients, and in his own community, his influence and example were potent factors, always standing for the best and highest things. And he verily laid down his life for his friends.

Sad it is indeed, that two such men should have been laid aside just at this time, when they had attained the place of honor, and neither of them able to enjoy it. The loss, however, gentlemen, is ours, and although we cannot have their presence, their counsel, and their leadership, yet we can, and do, have their example, and I am sure if we emulate their virtues, we will receive a tremendous uplift which will make of us better men and better physicians.

I realize my own limitations, and appreciate how very far short I shall come of serving you as well as they would have done, but I shall do my very best, and I can assure you that the mistakes I shall make will be of the head, rather than of the heart, and I crave your indulgence and ask for your hearty co-operation in making this the 140th annual meeting a success and, if not one of the best, I hope, at least, it will not be the worst in its history.

As we have a full programme, and many excellent papers, it will be necessary for the meetings to begin punctually; therefore I shall ask your prompt and constant attendance. I shall expect the readers of papers, as well as those who take part in the discussions afterward, to observe the time limit. I shall hope to see every one present at the opening of the sessions, and I trust you will find them sufficiently interesting to keep your attention until each session adjourns. If each one feels his individual responsibility, and tries to fill his place, then I am sure that we shall have a pleasant and profitable meeting.

Dr. Daniel Strock, of Camden, Chairman of the Committee on Credentials, reported that Somerset, Hunterdon, Burlington and Warren counties were delinquent in their payments—these having been recently received by the Treasurer, but not one month before the annual meeting, as required by the By-Laws; therefore, the members of these societies are disqualified from participating in the business of this meeting. Dr. Strock then read the following letter:

CAMDEN, N. J., Jan. 10, 1906.

Emery Marvel, M. D., President Atlantic County Medical Society:

DEAR DOCTOR:—In response to your request for an interpretation of the constitutional provision for the filling of a vacancy in the annual delegation of a component society to the Medical Society of New Jersey, I submit the following opinion, which you will understand, in the absence of a meeting, has not been submitted to or approved by the committee on credentials:

You ask: "If such a vacancy exists, is the absent delegate to appoint his alternate?" Answer, No.

"Does the president of the component society have the power to fill the vacancy?" Answer, No.

"Does Article IV, Section 4 (c) of the constitution of the Medical Society of New Jersey cover this matter?" Answer, Yes.

The section, paragraph c, reads as follows: "In the absence of an annual delegate of a component society in good standing, the presiding officer of the Medical Society of New Jersey may, on the recommendation of the members present from the said component society, publicly fill the vacancy from among the associate delegates of said society, and such alternate shall have all the rights of an annual delegate."

It is plain this is the only way such vacancy can be filled, and it is the only provision made for the selection of alternate delegates.

When we consider that the annual delegate has a voice in transacting the business of the profession of the entire state we can appreciate that the constitution has very properly safeguarded his right and title to the office, thus adding to its importance and dignity.

It is not possible for another to usurp this position, as the annual delegate must present to the committee on credentials a certificate of election, signed by the president and secretary of the component society which he represents, which certificate and his right to membership must be verified by the committee, who then issue to him a certificate or badge attesting his standing.

In the absence of this formality, he fails to become an annual delegate, though present at the meeting of the State Society.

As a vacancy in the annual delegation can only occur at the time of the meeting of the Medical Society of New Jersey, by the absence or presumed absence of the annual delegate, therefore the framers of the constitution very wisely decided that such vacancy could only be filled by the presiding officer at such meeting where the vacancy occurred. And it must be done publicly—that is, in the presence of the society then in session.

And, further, the selection of an alternate dele-

gate is not mandatory. "The presiding officer... may... publicly fill the vacancy."

Presumably, in the absence of the entire delegation, or in case there is a contest in the delegation, it would be deemed advisable to have vacancies filled.

But, where these conditions do not exist, it might not be considered that the absence of a member of the delegation jeopardized the interests of the component society.

It is evident that the intent of the section is to insure that every component society shall be represented in the House of Delegates, if at least one of its members is present at the meeting.

Approved by the Committee on Credentials.

DANIEL STROCK.

Dr. Chandler:—I move that this report be received and placed on file. Seconded and carried.

Dr. Cummins:—Did I understand that Warren county was barred from participation in our proceedings?

Dr. Marcy:—Yes.

Dr. Cummins:—I wish to explain to the society the position of Warren County Medical Society, of which I am the treasurer. Our secretary had to go to the Pasteur Institute in New York City for treatment and the report could not be prepared in time.

Dr. W. B. Johnson:—I move that Warren county sit with us and take part in our deliberation. Seconded.

Dr. L. M. Halsey:—I think the proper course to pursue would be to have the delinquencies removed. Therefore, I offer an amendment: "That the delinquencies of Warren and Burlington County Medical Societies be removed. Seconded.

Dr. W. B. Johnson:—I understand that these societies have paid their assessments.

Chairman:—They have. One county was tardy and the other failed to send reports to the secretary.

Dr. E. Hollingshead:—I move that Burlington county be excused.

Chairman:—I think that was included in the amendment. (Amendment and original motion carried).

Dr. C. R. P. Fisher:—On behalf of Somerset county I wish to state that I know why the treasurer was late. Our membership is so scattered and the treasurer was very anxious to get all the outlying members to make their payments; he was one or two days late because he hoped to get payments from all the members before this meeting. The money has already been paid in.

Dr. L. M. Halsey:—I think that my motion should go on the minutes. My original motion was that the delinquencies of Warren and Burlington counties be removed.

Chairman:—That motion has already been carried.

Dr. C. R. P. Fisher:—I move that the delinquencies of Somerset county also be removed. Seconded.

Dr. Archibald Mercer:—Check for payment from Somerset county was received May 31st—twelve days after the date fixed in the by-laws.

Dr. Chandler:—Before this matter is finally closed I wish to make a remark about both forms of delinquency. It is not by any means necessary to wait until every member has paid his dues. The treasurer of the county society should send at least what he has on hand one month before the annual meeting. That will place his society in good standing. He can add to that later, if necessary. The treasurer of this society will then be able to balance his books and get his report in proper order. It is still more important that the report to the recording secretary be made on time. It would be better if these reports were sent earlier than one month before the annual meeting. One month is too short a time in which to collate materials for the reports, to get up the programme, etc., etc., and send out notices for the annual meeting. While these societies may be excused this year, at the same time, I hold that we should adhere to a strict enforcement of the by-laws, which were devised with reference to the orderly and harmonious working of the business affairs of this society. We have increased in numbers very much in the last twenty-five years and it embarrasses our work if the reports are not sent in promptly at the time specified, (Motion carried).

The following persons, whose names are taken from the registration book, were present during the sessions:—

FELLOWS.—Charles J. Kipp, John W. Ward, H. Genet Taylor, John G. Ryerson, David C. English, C. R. P. Fisher, Luther M. Halsey, J. D. McGill, E. L. B. Godfrey, Henry Mitchell and Walter B. Johnson; total 11.

OFFICERS.—Alex. Marcy, Jr., First Vice-President; Edward J. Ill, Second Vice-President; David St. John, Third Vice-President; Daniel Strook, Corresponding Secretary; William J. Chandler, Recording Secretary, and Archibald Mercer, Treasurer. Total 6.

PERMANENT DELEGATES.

Atlantic County.—W. Blair Stewart, Atlantic City; E. A. Reilly, Atlantic City; W. E. Darnall, Atlantic City; J. Addison Joy, Atlantic City; E. C. Chew, Atlantic City; Emery Marvel, Atlantic City.

Bergen County.—Henry C. Neer, Park Ridge; David St. John, Hackensack; Samuel E. Armstrong, Rutherford.

Burlington County.—Enoch Hollingshead, Pemberton; R. H. Parsons, Mt. Holly; Walter E. Hall, Burlington.

Camden County.—Duncan W. Blake, Gloucester; Daniel Strook, Camden; William H. Iszard, Camden; William A. Davis, Camden; Alexander McAlister, Camden; Harry H. Sherck, Camden.

Cumberland County.—S. T. Day, Port Norris; Joseph Tomlinson, Bridgeton.

Essex County.—Joseph C. Young, Newark; Herman C. Bleyle, Newark; William J. Chandler, South Orange; Edward J. Ill, Newark; Charles H. Bailey, Bloomfield; Richard C. Newton, Montclair; James T. Wrightson, Newark; Theron Y. Sutphen, Newark; Thomas W. Harvey, Orange; Aaron K. Baldwin, Newark; David E. English, Milburn; Richard P. Francis, Montclair; Henry L. Coit, Newark; Edward Staehlin, Newark.

Gloucester County.—George E. Reading, Woodbury; James Hunter, Jr., Westville; Eugene T. Oliphant, Bridgeport.

Hudson County.—Jos. M. Rector, Jersey City; Frederick M. Corwin, Bayonne; Geo. E. McLaughlin, Jersey City; Mortimer Lampson, Jersey City; T. R. Chambers, Jersey City; Frank D. Gray, Jersey City; Gordon K. Dickinson, Jersey City.

Hunterdon County.—W. S. Creveling, Valley.

Mercer County.—R. R. Rogers, Sr., Trenton; Thos. H. Mackenzie, Trenton; Henry B. Costill, Trenton.

Monmouth County.—Henry Mitchell, Asbury Park.

Morris County.—Levi Farrow, Hackettstown; Cuthbert Wigg, Boonton; Stephen Pierson, Morristown; Calvin Anderson, Madison.

Passaic County.—W. B. Johnson, Paterson; P. A. Harris, Paterson; George H. Balleray, Paterson; Robert M. Curtis, Paterson.

Salem County.—B. A. Waddington, Salem; W. H. James, Pennsville; Henry Chavanne, Salem.

Somerset County.—J. P. Hecht, Somerville; Mary E. Gaston, Somerville.

Sussex County.—B. W. Ferguson, Beemer-ville.

Union County.—Alonzo Pettit, Elizabeth; E. B. Silvers, Rahway; James S. Green, Elizabeth; N. L. Wilson, Elizabeth.

Warren County.—G. W. Cummins, Belvidere. Total, 68.

ANNUAL DELEGATES AND REPORTERS.

Atlantic County.—David A. Berner and George Scott.

Bergen County.—Guy O. Brewster and Margaret P. Brewster.

Burlington County.—George T. Tracy and Wm. P. Melcher.

Camden County.—Paul M. Mecray, Dowling Benjamin and Wm. A. Westcott.

Cape May County.—J. Morgan Dix.

Cumberland County.—David H. Oliver and Ellsmore Stites.

Essex County.—Wm. Buermann, Linn Emerson, Thos. N. Gray, M. J. Synnott, F. W. Pineo, and Edward E. Worl.

Gloucester County.—

Hudson County.—Samuel A. Helfer, A. A. Strasser, Geo. H. Sexsmith, Oliver R. Blanchard, Hamilton Vreeland and John J. Baumann.

Mercer County.—William L. Wilbur.

Middlesex County.—H. H. Janeway.

Monmouth County.—

Morris County.—Henry M. Reilley and John Walters.

Ocean County.—Wm. H. Schaffler.
 Passaic County.—F. F. C. Demarest, James O'Donnell and Wm. H. Carroll.
 Salem County.—R. M. A. Davis.
 Somerset County.—
 Sussex County.—Morgan D. Layton and H. D. Van Gaasbeek.
 Union County.—Thomas P. Prout.
 Warren County.—
 Total—35.

ASSOCIATE DELEGATES.

Sophia Presley, Theodore Senseman, Edward Guion, Daniel Stout, H. V. Pike, Philip Marvel, L. M. Hummel, Daniel Garrison, John F. Smith, Henry H. Davis, Walter P. Conaway, Wm. A. Clark, E. H. Harvey, Anna M. Richardson, Walter Reynolds, W. M. Pollard, J. S. Baer, F. C. Ard, F. J. Keller, D. D. Hendrickson, S. G. Bushey, J. A. Chard, J. F. Finn, Fred. A. Finn, Edw. B. Rogers, Wm. J. Lalor, Thos. K. Reed, Chas. B. Smith, John L. Taylor, John J. Brodrick, J. G. Edwards, Wm. H. Walling, A. D. Cuskaden, J. Anson Smith, F. G. Stroud, E. B. Bradford, H. W. Kice, H. A. Wilson, J. E. Blair, C. Garrabrant, Clara K. Bartlett, J. E. McVay, D. A. Currie, P. DuBois Bunting, Mary E. Townsend, Henry Kip, A. E. Carpenter, E. K. Conrad, Irwin H. Hance, J. W. Fithian, W. B. Fayerman, W. L. Ewen, J. F. Leavitt, H. C. James, S. F. Stanger, Chas. L. Heritage, Wm. F. Ridgeway, Randolph Marshall, Jno. W. Bennett, M. H. Leaver, Wm. C. Parry, Wm. B. Jennings, H. F. Palm, A. M. Ellwell, E. C. Pechin, Alex. Marcy, Sr., H. G. Norton, M. S. Ireland, T. G. Dunlap, S. T. Doriss.
 Total—70.

GUESTS.

E. E. Montgomery, H. D. Beyea, Louis Borsch, Ernest Laplace, H. A. Hare and Judson Daland, Philadelphia; E. Franklin Smith, New York; F. Raymond Keating, Atlantic City, and Damon B. Pfeiffer, Williamstown.

DELEGATES FROM STATE SOCIETIES.

Charles P. Noble, Pennsylvania; William M. Leszynsky, New York, and A. H. Hodgden, Massachusetts.

The following Permanent Delegates were absent: Wm. S. Jones, Camden; Charles Young, Geo. R. Kent, Theo. W. Corwin, Rich. D. P. Dieffenbach, J. W. Read, Geo. A. Van Wagenen, Chas. F. Underwood, L. E. Hollister, Chas. D. Bennett and Robert G. Stanwood, Newark; Daniel M. Skinner, Belleville; Thomas S. Fitch, and Wm. B. Graves, East Orange; Geo. B. Philhower, Nutley; J. A. Exton, Arlington; Isaac S. Cramer, Flemington; David Warman, Elmer Barwis, C. F. Adams and J. C. Felty, Trenton; Geo. N. Best, Rosemont; Geo. H. Franklin, Hightstown; Ambrose Treganowan, South Amboy; F. M. Donohue, New Brunswick; D. M. Forman, Freehold; Edwin Field, Red Bank; F. C. Price, Imlaystown; Samuel Johnson, Asbury Park; F. E. Flagge, Rockaway; David Stephens, New Brunswick; Cyrus Knécht, Matawan; A. A. Lewis, Morristown; B. D. Evans, Morris Plains; John L. Leal, C. H. Scribner, John T. Gilson and Andrew F. McBride, Paterson; Chas. L. Lindsley, Lakewood; S. O. B. Taylor, Millstone; A. L. Stillwell, Somerville; J. A. Coles, Scotch Plains; T. H. Tomlinson, Plainfield, and T. N. McLean, Elizabeth.

The following Permanent Delegates have been absent from two consecutive annual meetings: Wm. S. Jones, Camden; Thomas S. P. Fitch

and Wm. B. Graves, East Orange; C. F. Adams, Trenton; Samuel Johnson, Asbury Park, and F. W. Flagge, Rockaway.

READING OF THE MINUTES OF THE LAST ANNUAL MEETING.

Dr. Chandler stated that the printed record of last year omitted to state the amount fixed for the annual assessment. With this correction, he moved that the reading of the minutes be dispensed with and that the record of the proceedings, as published in the Supplement to the JOURNAL for September, 1905, be approved as the minutes of the last annual meeting. Seconded and carried.

ELECTION OF PERMANENT DELEGATES.

Dr. Chandler:—The Committee on Credentials reported only one as eligible for election, Dr. Emery Marvel. The credentials of Dr. Gray and Dr. Dickinson have not been received, and no report has been made.

Chairman:—There has only one name been received and, therefore, but one candidate, Dr. Emery Marvel, of Atlantic City. Gentlemen, what is your pleasure?

Dr. Henry M. Reilly:—I move that Dr. Emery Marvel be elected a permanent delegate. Seconded.

Dr. T. J. McLoughlin:—Dr. Dickinson has been nominated for election as permanent delegate by Hudson county. He could not be here this morning, but he expects to be present this afternoon. It seems unfortunate that he cannot be balloted for. Dr. Gray is here, but through some error he could not be present at this time.

Chairman:—If the credentials of these gentlemen were here it would not matter whether they were present or not.

Dr. McLoughlin:—Could not this matter be taken up later?

Dr. Taylor:—I move that the secretary be instructed to cast the ballot for Dr. Emery Marvel, of Atlantic City.

Chairman:—By precedent, it has been established that the election must be by ballot.

Dr. Frank D. Gray:—A member of the House of Delegates just called my attention to the fact that it is assumed that my credentials, also those of Dr. Dickinson, for permanent delegate have not been presented. They are now in the hands of the secretary. It was my oversight in not knowing what formality was necessary in order to gain a permanent delegacy.

Chairman:—The secretary informs me that the credentials are not in proper form.

Will you please correct them and then we will take this matter up later.
I will appoint Dr. Halsey and Dr. Reilley tellers.

Tellers.—We have the honor to report that 38 votes have been cast, all in favor of Dr. Emery Marvel.

Chairman.—I declare Dr. Emery Marvel elected as a permanent delegate from Atlantic county.

ANNOUNCEMENT OF COMMITTEES BY THE CHAIRMAN.

Chairman.—I have only to announce the Prize Essay Committee; it consists of Drs. Kipp, English and Johnson.

REPORT OF COMMITTEE ON ARRANGEMENTS.

The Committee of Arrangements begs to report that arrangements have been made to hold the One Hundred and Fortieth Annual Meeting of the Medical Society of New Jersey at the Hotel Chelsea, where desirable rooms are provided for the meetings, and comfortable accommodation is afforded the members of the society.

Suitable conveniences are provided for the exhibition of such articles as may be of interest to the members in rooms nearby the meeting hall. These spaces are offered to only those exhibitors of chemical remedies that are willing to give the formula of the composition of the article exhibited.

In acting in accordance with this policy the committee has declined a number of applicants, and of those accepted it has been guided by the decision of the *Journal* of the American Medical Association and the *Journal* of our State Society, accepting as proper exhibits those which these journals have accepted as advertisers in their columns.

Entertainments have been provided for the ladies for which the committee wishes to acknowledge the assistance of the wives of physicians of Atlantic county, and especially Mrs. A. D. Cuskaden, who has been an active chair-lady of the Ladies' Committee.

An excursion to Longport, Somers Point, and the Country Club of Atlantic City, have been arranged for this Tuesday afternoon, the party leaving at two-thirty (2.30).

The Yacht Club, of Atlantic City has invited the ladies to its club house and to take a boat ride to-morrow, Wednesday, afternoon, leaving the hotel at half after two (2.30).

A vaudeville entertainment will take place in the music room of the Hotel Chelsea, Wednesday evening, from 8.30 to 10.30. This entertainment will be followed by dancing. The music furnished by the Hotel Chelsea orchestra by courtesy of the hotel.

The members and visitors are invited by the Infant Incubator Institution to visit the institution on Young's Pier any time Thursday. Premature infants are being cared for at this institu-

tion and will no doubt prove of interest to the visitors.

By courtesy of the management of Young's Pier, the members and visitors are invited to see the net haul on the pier at 10 A. M. and 4 P. M., Thursday.

The money receipts of the committee have been limited to the revenue gained from the exhibition spaces. The sum of three hundred and thirty dollars has been collected. The expenses are estimated to be three hundred and fifteen dollars.

Respectfully submitted,

E. C. CHEW,
E. HOLLINGSHEAD,
P. M. MCCRAY,
THEODORE SENSEMAN,
EMERY MARVEL, *Chairman*.

Dr. Kipp.—I move that this report be received and that the thanks of the society be tendered Dr. Marvel for the work that he has done. Seconded and carried.

REPORT OF COMMITTEE ON HONORARY MEMBERSHIP.

To the Medical Society of New Jersey:

Your Committee on Honorary Membership begs leave to make the following report on the nomination of Dr. S. A. Knopf, of New York, for membership in this society.

Dr. Knopf is the author of the international prize essay on tuberculosis.

At the time of the joint hearing before the Legislature of New Jersey on the bill to establish a hospital for the consumptive poor of this State, Dr. Knopf came on from New York, and made an able plea before the committee.

It is hardly necessary to state that he is always ready to give his time and services in any movement for the eradication of the great white plague, and it is with pleasure that we recommend him for honorary membership in this society.

H. GENET TAYLOR,
L. M. HALSEY.

Chairman.—It has been moved and seconded that the report be received and that the recommendations be complied with. It requires two-thirds vote of the House of Delegates to elect.

Dr. Kipp.—I move you that the secretary be instructed to cast the ballot. Seconded.

Chairman.—The secretary informs me that he has cast the ballot which elects to honorary membership Dr. Knopf, of New York City.

Dr. Taylor.—I believe that, according to the by-laws, only fifteen honorary members are allowed. I should like to ask how many we now have.

Chairman.—The number of living members shall not exceed fifteen.

Dr. Chandler.—We have eleven. With the one just elected our number is twelve.

INTRODUCTION OF BUSINESS REQUIRING EARLY ATTENTION.

Chairman:—It has been moved and seconded that the corrected certificates presented by Dr. Gray and Dr. Dickinson, of Jersey City, be accepted, thus making them candidates for permanent delegates. We will now proceed to vote for their election and I will appoint again Dr. Halsey and Dr. Reilley, tellers.

Tellers:—We wish to respectfully report that Dr. Gray and Dr. Dickinson have been elected permanent delegates.

Dr. Halsey:—I wish to introduce the following resolution:

Whereas, The Medical Society of New Jersey has heard with deep regret of the affliction which has come upon our President, Dr. Henry W. Elmer, and

Whereas, It is particularly sad at this time when he would have enjoyed the highest honor within the gift of his medical brothers of this society; therefore, be it

Resolved, That we, the Medical Society of New Jersey, extend to his family our heart-felt sympathy in this, their affliction, and assure them that his name will be a treasured memory to us all for his devotion to the interests of the Medical Society of New Jersey and for his ever ready and willing acceptance of any duty which was assigned to him and which had for its object the advancement of the medical profession of this State.

Dr. Kipp:—I wish to make an amendment to the resolution just read, that the secretary be instructed to telegraph the family of Dr. Elmer of our action. Seconded. (Amendment and resolution carried).

Dr. Chandler:—I am requested to read the following letter from Dr. Henry O. Marcy, of Boston, soliciting funds for the erection of a memorial to the late Dr. Davis, of Chicago:

March 9, 1906.

MY DEAR DR. ILL:—You have been appointed co-associate with me as a representative of your State to solicit funds for a proper memorial to the late Dr. N. S. Davis, of Chicago, as the founder of the American Medical Association. We do not require a large sum of money, but would much rather secure a small contribution from many who loved him and who will consider it a privilege to thus honor him. Two hundred and fifty dollars from a like number of your Medical Association members would be appreciated more than twice the sum from a single individual. If voted from the fund of the State Society would it not equally represent all the membership?

HENRY O. MARCY, *Chairman*.

Dr. Chandler:—I move that this matter be referred to the Committee on Business. Seconded and carried.

REPORT OF THE COMMITTEE ON PROGRAMME

To the Medical Society of New Jersey:

The Committee on Programme in presenting its report desires not only to call attention to the neat little booklet containing the order of exercises, &c., but it especially wishes to offer a suggestion relating to the general distribution of the programme in this form.

It has been customary for many years to send a copy of the programme to each member of the county societies, to exchange with each of the State societies, to send out many complimentary copies and in addition to have a supply of 400 to 500 for the use of the society at the annual meeting. This requires an edition of 2,000 copies. The expense of publishing is about \$40.00. The cost of wrapping, addressing and mailing, including postage, is between \$20.00 and \$25.00. The total cost is therefore about \$60.00 to \$65.00.

As we are now publishing a journal, we could print the programme in the journal and send it out thus to each of our members, and to many of our exchanges, for much less than it costs now. From the same type used in the journal we could print 500 or 600 reprints in the form of our present programme for use at the annual meeting. The total expense would not be half what it is now.

If the society should approve of this course we can adopt it next year.

At our last annual meeting a motion was made that the "meetings of the House of Delegates be separated entirely from the scientific sessions." After some discussion the matter was referred to the Committee on Programme, with instructions to report this year.

Your committee has communicated with many members of the society and the general consensus of opinion is that any other separation than that which now exists would be most undesirable. It would divide our interests, and while some of our number would prefer to attend the legislative sessions, and others care only for the scientific papers, the large majority is concerned with both branches and would feel it a great annoyance to be deprived of the privilege of attending such portions of each of these sessions as may be likely to be of interest.

A motion was made last year "that the society be divided into a medical and a surgical section, and that the two be separate." Objections, similar to those already presented, hold against this plan. The object desired can be attained in a better way, viz.: by the arrangement of the programme. This has been especially considered by your committee and in the grouping of papers. The Wednesday morning session is devoted entirely to medical topics, while the Wednesday afternoon session is occupied with surgical subjects.

The committee reports unanimously against making either of the changes.

Respectfully submitted,
ALEX. McALISTER,
F. F. C. DEMAREST,
WM. J. CHANDLER, *Chairman*.

Dr. Reilly:—I move that the report be adopted. Seconded.

Dr. Kipp:—I wish to make an amendment; that the recommendations be concurred in and that the Board of Trustees

be requested to carry out the recommendations. Carried.

REPORT OF COMMITTEE ON SCIENTIFIC WORK.

Reports from 13 counties have been received.

Progress is noted, and good work has been done in all except three counties.

Papers and discussions have covered a wide field. Inspiration and instruction have been sought outside the state; 12 doctors and professors have come from New York and Brooklyn, and 5 from Philadelphia.

Medical libraries have been started in four counties. Essex has the banner report this year, with her 150 \$3-per-annum subscribers and one life subscriber at \$50., 750 volumes and 40 current medical periodicals properly housed. Hudson will give a good account of herself next year. Mercer is in earnest, increasing her initiation fee to \$5.00, and annual dues to \$10. Sussex has made a start.

The societies, by their combined efforts, have made a mighty showing in influencing legislation. Dr. L. M. Halsey says: (see No. 1).

The fight vs. mosquitoes, at the request of the committee, has been described by Prof. J. B. Smith, of New Brunswick; (see No. 2).

The White Plague contest has been described by Dr. Geo. E. McLaughlin, of Jersey City; (see No. 3).

And the N. J. Association for Prevention and Relief of Tuberculosis is reported by Mr. Wm. C. Smallwood, Newark, secretary of the association.

NORTON L. WILSON,
R. H. PARSONS,
TALBOT R. CHAMBERS, *Chairman*.

No. 1.

I will try to give you a little synopsis of the work of the Legislative Committee during the year.

I think the main thing that has been accomplished has been the fairly good organization which we have at the present time in our county societies in conjunction with the State and National Auxiliary Legislative Committees. If this is kept up it cannot but help be very effective in the future in all matters pertaining to legislation, as it should be a very easy matter to come in close touch with the members of the Legislature through these various committees and the county societies.

Our ability to prevent osteopathic legislation at the past session was due to this more than to any other thing.

We were not able to pass the Patent Medicine bill, largely, I think, because the same amount of work was not expended on this as was brought to bear against the osteopathic measure. If the average doctor was able to grasp two things at a time, and there had been as much conscientious work done for this bill as against the other, I think we would have gotten it through the Legislature.

We assisted in passing some measures which were asked for by the State Board of Health as amendments to the present law, giving local boards of health more power.

The free antitoxin bill we supported. I am satisfied that the time has arrived in which the members of the Legislature feel that the medical

men of this State are a power provided their work is exerted in a definite direction.

L. M. HALSEY.

June 14th, 1906.

No. 2.

By Prof. J. B. Smith, New Brunswick (No. 2)

During the calendar year beginning June 1, 1905, a great deal of work looking to the extermination of mosquitoes has been done in New Jersey and this work has been widely distributed throughout the State.

The general public has been educated to the point of recognizing the mosquito as a danger to public health, and individuals as well as communities are active in seeking and eliminating breeding places. The Duffield amendment to the health law, which declared "water in which mosquitoes breed" as an abateable nuisance, has enabled Boards of Health to take cognizance of many cases which in times passed have been ignored. It goes without saying that from all points of view the elimination of stagnant pools is an advantage. The cities of Newark and Elizabeth have been perhaps most active in their campaign against breeding places as a measure of sanitary importance, but many of the smaller towns and villages have made notable improvements.

In this connection the work of the Conference Committee on Mosquitoes should be referred to. This is a voluntary organization meeting at Newark, in the rooms of the Board of Health and its membership is composed of representatives from health boards and improvement associations from the counties of Essex, Union, Hudson, Bergen and even Morris. This organization has had a powerful influence in extending the work and is responsible to a large extent for that now nearing completion on Staten Island.

This work on Staten Island is of direct importance to New Jersey because from the meadows adjacent to the Kill, millions of mosquitoes came into the State each year and these will be for the future, conspicuously absent. Dr. A. H. Doty, State Quarantine Officer, has been in general charge of this work and, when completed, it will come near to being an illustration of what such work should be.

In New Jersey the city of Elizabeth has spent \$2,500 in work on the salt marshes within its jurisdiction and has eliminated breeding places from a large marsh area; but, unfortunately there were not sufficient funds to complete the work and a large surface of breeding places still exists. The benefits of the Elizabeth work will be felt at a distance from that city more than in the city itself.

On the Shrewsbury river the breeding places at Port-au-Peck and in its immediate vicinity have been finally eliminated and except for a small area within the jurisdiction of Long Branch, the entire course of the river is free from mosquito breeding areas.

Finally, it should be noted that the State has recognized its duty in the matter and has passed an act, titled Chapter 134, Laws of 1906, providing for the expenditure of \$350,000 in work chiefly along shore, looking to the elimination of the breeding places of the marsh or migratory species. Unfortunately only \$10,000 has been made available for actual work during the fiscal year 1906-07, beginning November 1, 1906, so

that only a comparatively small beginning can be made until more funds are in hand.

No. 3.

Abstract of Report of Progress against the White Plague—George E. McLaughlin, Jersey City.

The meeting of the International Congress of Tuberculosis in Paris afforded an opportunity for reviewing the progress that has been made during the past few years, but the conclusions arrived at cannot be said to have chronicled decided advance in knowledge.

The majority of those presenting communications was of the opinion that no precise difference, which could be considered constant, existed between the pathogenic organisms of tuberculosis in mammals, birds or cold-blooded creatures, either in respect to morphological characteristics or in their reaction to staining reagents.

Prof. Von Behring made a statement in which he explained that he had been successful in producing a "cellular" rather than an antitoxic immunity and that it was induced by a modified constituent of the tubercle bacillus. He believed that this substance which he had termed T. C., can be elaborated "in vitro" in such a manner as to be capable of utilization in the treatment of human tuberculosis. It is to be hoped the future may bring equally good results as have been obtained from his antitoxic treatment of diphtheria.

An anti-tuberculosis league was formed last winter in Jersey City and two lectures were given in our Free Public Library on this topic. The idea is to educate the people to a proper understanding of the modes of infection in this disease and also in the lines of good sanitary hygiene. An attempt is to be made to establish a tuberculosis camp in the county. The league is in its infancy, but within a year hopes to be actively at work. It is composed of physicians, laymen and a number of ladies who are interested in other lines of work, especially day nursery and settlement.

Summary of Reporters' Reports.

Atlantic County.—Dr. A. Burton Shimer, Atlantic City, Reporter. General interest in attendance and character of meetings held. Dr. Robt. Morris, New York, "Cobwebs in the Attic of the Abdomen"; Dr. B. C. Hirst, Philadelphia, Talk on "Lacerations of the Genital Canal and Retroversion." March 2d, Symposium on Tuberculosis: Dr. Senseman, "Early Signs"; Dr. Walter Reynolds, "Treatment"; Dr. E. Guion, "Prophylaxis"; Dr. T. F. Dunlap, "Some Manifestations Other Than Pulmonary." Ten new members; one removal and no deaths. Slight epidemic of measles. The Committee on Legislation was represented at every meeting of the State Committee at Trenton. They presented to the legislators a series of resolutions. (These are not incorporated here because they will probably be referred to by the Committee on Legislation.) The Board of Health has been active in the examination of foods on sale at Atlantic City. The Health Office has a complete file, open to the public, of the condition of the dairies supplying milk to Atlantic City. A few dealers have been prosecuted for having in their possession adulterated milk. The sewage company reports a remodeling of the entire sewage system of Atlantic City at an outlay of over \$500,000.

Bergen County.—Dr. James W. Proctor, Englewood, Reporter. The quarterly meetings fairly well attended. Dr. C. G. Kerley, of New York, and Dr. E. H. Bartley, of Brooklyn, read on "Infant Feeding." Improving the water supply and the conditions of the jails has engaged the attention of the Society. Committees have been active in helping the defeat of the osteopath bill. Scarlet fever has been almost an epidemic, chiefly because of its mild type. Some of the cases not being recognized till desquamation stage.

Burlington County.—Dr. W. P. Melcher, Mt. Holly, Reporter. Eight responses to 38 postal sent members of the Society causes the Reporter to complain. Dr. Marcy, of Riverton, notices a falling off of appendicitis and suggests a possible casual relation between this disease and influenza which has been much less in evidence than in former years. In Pemberton the public schools were closed for two weeks on account of an epidemic of measles. Dr. Shipps, of Bordentown, reports three interesting cases. (See printed report.) Dr. Parsons, Mt. Holly, reports three cases of typhoid since February and an examination of the water by the State Laboratory of Hygiene classed it as "evidently polluted." Prof. H. Leffman (Philadelphia), after his examination, claims the water excellent and suitable for domestic purposes. Several new members, and two deaths, Dr. N. N. Stokes, Moorestown, and Dr. J. H. Pugh, Burlington.

Camden County.—Dr. E. B. Sharp, Camden, Reporter. Four new members; 89 membership; 2 deaths. At the beginning of the year the work of the Society was divided into sections. The following papers were presented and discussed: Dr. Palm, "The Modern Tenement House an Unsanitary Proposition"; Dr. S. Coles, Philadelphia, "Acute Nephritis Complicating Pregnancy"; Dr. Wills, "Trichina and Trichinosis in Camden"; Dr. Lippincott, "Treatment of Ano-rectal Fistulas in the Tuberculous"; Dr. Cramer, "Syphilitic Affections of the Eye"; Dr. J. B. Shobes, Philadelphia, "Cystitis of the Female Bladder"; Dr. Baer, "Extra-uterine Pregnancy." All revealed thought and research. The Committee on Osteopathy was active. Camden city had 299 cases of scarlet fever with four deaths. There were only 39 typhoid cases in a population of 85,000, and most of those cases could be traced to outside sources.

Cape May County.—Dr. M. F. Lummis, Holly Beach, Reporter. We adopted the printed resolutions of the Camden County Medical Society, and sent them to our representatives in the Legislature. We decided to hold quarterly instead of semi-annual meetings. April Dr. P. Marvel outlined the duties of officers and discussed ways and means for increasing interest in our Society. Dr. M. M. Franklin, Philadelphia, "Acute Surgical Conditions in Right Side of Abdomen, Especially Lower Quadrant." Wide spread epidemic of pertussis, measles and mumps. One new member.

Cumberland County.—Dr. S. M. Wilson, Bridgeton, Reporter. Four meetings; three members moved, from county; one died, Dr. O. H. Adams, Vineland. Dr. Henry W. Elmer has been seriously ill the entire year. Dr. S. E. Ewing of Leesburg has been incapacitated by diphtheria. There has been united and hearty action against the osteopathic bill. Several members have been added to the roll. Forty-four members.

Essex County.—Dr. Frank W. Pinneo, Newark,

Reporter. Five regular meetings and one special meeting have been held. June, clinical meeting. October, L. M. Hurd, New York, "Submucous Operations for Deviated Septum of the Nose." December, Dr. George L. Meyland, New York, "Effects of Physical Exercise on the Heart." February, J. H. Huddleston, New York, "Public Control of Tuberculosis." Dr. W. S. Disbrow, "Possible Dangers of Water Gas." At the special meeting resolutions were adopted versus the State osteopath bill and favoring the national pure food and drug bill, and a delegation was sent to Trenton. A resolution was passed versus contract physicians. In February a tuberculosis exhibition was held in Newark. Eleven thousand visitors viewed the profusion of pictures, models, books, charts, etc., showing the history of the treatment (or neglect), its communicability, the work of tenement house and similar commissions, the plans of various sanatoria, including our own New Jersey institution; and circulars of useful public instruction designed to protect the healthy and to guide and encourage the affected. There has been started in Newark an anti-tuberculosis society to join hands with the State and national organizations. A medical library has been founded and is well started. One hundred and fifty subscribers at \$3 per annum and 150 life members. There are 40 current periodicals and 750 medical volumes. The William Pierson Medical Library Association of Orange, has held regular meetings at which papers were read: Dr. J. R. Goffe, "A Medical Hero—Dr. Thomas Wakeley"; Dr. A. B. Duel, New York, "Modern Treatment of Suppurative Otitis"; Dr. W. H. Park, New York, "Hygiene of Milk"; and a symposium on medical education by Dr. R. C. Newton, Prof. S. W. Lambert, New York, and Ellsworth Eliot, New York. Thirty new members and three died, Drs. C. M. Zeh, James Elliott and P. V. P. Hewlitt.

Hudson County.—J. H. Rosenkranz, Hoboken, Reporter. Four well attended and interesting meetings. Dr. G. K. Dickinson, "Suparietal Injuries of the Abdomen." In December Symposium on Interstitial Nephritis; Dr. C. W. Crankshaw, "Etiology"; Dr. W. W. Brooks, "Symptoms"; Dr. J. J. Broderick, "Diagnosis"; Dr. L. Franklin, "Medical Treatment," and Dr. F. D. Gray, "Surgical Treatment." In February Dr. W. F. Faison, "Gastric Ulcer," discussed by Dr. Samuel Lloyd, New York. In April, Dr. F. N. Corwin, "Proprietaries," discussed by Dr. R. C. Newton, Essex. The Legislative Committee was very active and did good work on the floor at Trenton versus osteopath bill. Pneumonia has had a large death rate.

Mercer County.—Dr. J. J. McGuire, Trenton, Reporter. Four men were expelled after formal trial for continuing in contract work; two have signified their intention of reapplying for membership. One has been reelected to membership, having relinquished membership in the Trenton Emergency Hospital, which was founded for the purpose of furnishing at \$1 per year medical and surgical treatment. There are only two men now doing contract work. In order to increase the efficiency of the Society it has been determined to secure permanent quarters and to have a medical library. The initiation fee was raised to \$5 and annual dues to \$10. This was done after a canvass of the entire membership and adopted unanimously. Realizing the great financial loss physicians sus-

tain from indiscriminate treatments in dispensary work of the various hospitals, the physicians in attendance were notified to eliminate as far as possible the unworthy. Prof. J. C. Wilson, Philadelphia, "Para-typhoid"; Dr. M. G. Schlaff, "On the Atrophies." Seven new members; eight suspended for non-payment of dues. Two died, Dr. B. W. McGalliard and Dr. Lyman Leavitt. Board of Health of Trenton reported 326 cases of scarlet fever with four deaths. Diphtheria 129 cases with 14 deaths. Typhoid fever, 67 and no deaths. Tuberculosis, 24, and 1 death. Of scarlet fever there were an average of 40 cases reported per month for the last seven months.

Morris County.—Harry S. Wheeler, Whippany, Reporter. Four well attended meetings. Dr. H. M. Reilley, "Purpura Hemorrhagica"; Dr. H. A. Cossitt, "Bacteriology in Pneumonia"; Dr. L. Ely, "Osteopathy"; Dr. F. W. Owen, "The Practitioner in Business." One meeting was held at Morris Plains Hospital. Dr. B. D. Eyans and Dr. P. S. Mallon lectured on "Paranoia"; Dr. F. H. Seward on a "Genito-urinary Subject"; Dr. Winfield Ayres, N. Y., "Importance of the Cystoscope in Genito-urinary Organs," followed by demonstrations at Morristown Memorial Hospital. Pneumonia has been very prevalent, and rubella, scarlet fever and mumps have been epidemic. One death and four new members.

Ocean County.—Dr. W. G. Schauffler, Lakewood, Reporter. Two meetings. The Reporter wrote to all the physicians and only received three replies. Healthy year.

Sussex County.—Dr. H. D. Van Gaasbeck, Sussex, Reporter. Meetings poorly attended; one death, Dr. J. E. Hedges; 1 removed. Dr. Hunt, of Green Township, was elected to honorary membership. He offered to donate his library of 300 volumes to form a nucleus for a county medical library. The Reporter suggests that the State Society appoint some prominent member of the profession to meet with the weaker county Societies and read a scientific paper at their annual meetings in the hope of arousing more interest among the members.

Union County.—Dr. Milton A. Shangle, Elizabeth, Reporter. Four regular meetings; all interesting and instructive. Dr. Van Horn, "Aseptic Midwifery"; Dr. F. C. Ard, "Malignant Growths of the Larynx"; Dr. N. L. Wilson, "Intra Tracheal Injections"; Dr. Murray, "The Fight vs. Tuberculosis." Dr. Wilson reported a case of "Abscess of the Brain" and "Kilian Operation for Frontal Sinusitis and Ethmoiditis"; Dr. B. Van D. Hedges, "Bursitis"; Dr. VanHorn, "Inguinal Herniotomy in a Child Three Years Old"; Dr. S. T. Quinn, "A Case of Pleural Empyema and Subphrenic Abscess"; Dr. F. C. Ard, "Epithelioma of Eyelid." The committee and especially Dr. Wilson are to be commended for their efforts versus the osteopath bill. Eighty-two members; lost one by death and three by resignation. Healthy season.

Chairman.—It has been moved and seconded that this report be accepted with the thanks of the society. Carried.

Dr. Armstrong.—I ask for the privilege of the floor. As I am compelled to take the 2.30 train I should like to be able to dispose of the Mosquito Committee's report. I

desire to read this report and also to nominate a candidate for honorary membership.

Chairman:—Your request is granted. I will first read to you regarding Honorary Membership. (Read from By-Laws).

Dr. Armstrong:—The man whom I would place in nomination for honorary membership has been long and favorably known in surgical and educational centres—Dr. Albert VanDerveer, of Albany.

Dr. Chandler:—I move that the nomination take the usual course and be referred to the Committee on Honorary Membership. Seconded and carried.

REPORT OF COMMITTEE ON MOSQUITOES AND MALARIA.

Dr. S. E. Armstrong:—This report is made from my own resources and my colleagues are in nowise responsible for the views advanced:

MR. PRESIDENT:—The great problems involved in the causation and prevention of malaria have been the subjects of careful study by eminent men in various parts of the world for many years. Up to the year 1880, when Laveran made his famous discovery, the miasmatic theory held greatest sway, but it was not until the year 1898 that Manson, Ross and others showed that the infection is spread through the agency of the mosquito, *i. e.*, the single variety known as the anopheles. Since that time other insects, notably the bed-bug, have been accused of performing a similar function, and, just recently within the present year, Sehrwald, a Brazilian physician, claims to have discovered the presence of the plasmodium in the intestinal tract and mucuous glands of the mouth of the book-worm. We are not aware that any other observer has confirmed this report; however, it may be regarded as proven beyond a doubt that, first, the plasmodium of Laveran is the etiologic factor in the production of malaria; second, the source of infection is through the bite of an infected or a germ-bearing mosquito in practically every instance so far as this locality is concerned. It may further be regarded as proven that the methods of prevention of malaria are to be divided into two principal classes: First, isolation of infected persons by the use of mosquito-netting or screens; second, the destruction of the insects in some one or by a combination of two or more of the following methods: (a) By emptying all receptacles containing water which may furnish a breeding place; (b) by filling in or draining all pools, swamps or other bodies of water within the anopheles, striking distance of infection, and this distance is probably only a few hundred feet; (c) by planting those streams or other bodies of water which are not susceptible to the former treatment with small fishes, as they will destroy the wrigglers long before they reach maturity; (d) in cases where none of the former methods are applicable by pouring crude oil on the surface of the water. This will suffocate the wrigglers.

At the 1901 meeting of this Society, held at Deal Beach, the chairman of this committee read a paper in which he, without claim to original discovery, set forth the above doctrines. That was one year after the army commission, headed by Major Walter Reed, M. D., commenced its study of the causes of infection producing yellow fever on the Island of Cuba. That paper was received by this Society with an amount of incredulity almost amounting to a yawn; indeed, one speaker said in the early part of his remarks: "I have been looking around me and I see many of the members nodding," and he immediately sallied forth with a hilarious story and an account of his own efforts to discover the "malaria bacillus," as he put it, and in which he wound up by discovering a sulphur factory and making himself ridiculous. But, Mr. President, these doctrines are received to-day as being gospel truth by the entire enlightened world. I suspect that even the gentleman who poked fun at them at the Deal Beach meeting believes in them to-day. The main object in setting this committee forth was to give the Society's endorsement to them and to the end that its efforts, meagre though they must be, might be generally educational. The only excuse this committee has for its existence to-day is that it may hand in this final report and receive its honorable discharge; but before that word is given we would like to call your attention to the following statistics sent out by our State Board of Health and also to the chart kindly furnished this committee by Dr. Mitchell. We give you both the statement and the statistics:

The average number of deaths caused by malarial affections in New Jersey during the past twenty-seven years has been one hundred and eighty-two, and for the fourteen years, 1879-1892, the average number of deaths in the State from malaria was two hundred and fifty-six. The diminishing mortality from this cause has been very marked during the past eight years: 1898, 82; 1899, 96; 1900, 84; 1901, 50; 1902, 36; 1903, 40; 1904, 43; 1905, 30; and the remarkable falling off in deaths for the past few years leaves no doubt that some unusual influence has produced this improvement. No new methods of treatment have recently been introduced, and only one explanation of the decrease in the prevalence of this disease has been suggested, *viz.*: the recognition of the cause of the malady and the application of rational measures to reduce the extent of mosquito-breeding areas.

If anything more is needed to prove a theory we might call your attention to the wonderful success achieved in New Orleans last year in handling a most threatening epidemic of yellow fever. The deaths numbered a few hundred—about four hundred, I think—whereas during the epidemic of 1897, when these sanitary methods were not employed, the deaths numbered as high as four thousand. Of course, yellow fever is not malaria, but the mode of infection and the means of prevention are just the same in both diseases.

Chairman:—This is a very creditable report and Dr. Armstrong should be thanked. Some time ago the presentation of such a paper would be received with credulity and more or less ridicule. Since I have been associated with this committee I can testify to the earnestness and untiring efforts that

have been made along this line and I believe these gentlemen to be entitled to the thanks of the society before they are discharged.

Dr. Taylor:—I move that the report be received and placed on file and that the committee be discharged with thanks. Seconded and carried.

REPORT OF COMMITTEE ON PUBLICATION.

To the Medical Society of New Jersey:

Last year in entering upon a new field of labor the work of the Committee on Publication was very much embarrassed by the sickness of one of its members. As a result, the whole responsibility devolved on the two remaining members. This year, with a full committee continuously and actively engaged, the work has been relatively lighter, although absolutely greater in amount.

The chief business of this committee is the publication and management of the JOURNAL. It is, however, consulted and interested in all printed matter sent out in the name of the Society—the stationery, the publication of the programme, and, this year, the circulation of copies of the "Principles of Ethics."

The second volume of the JOURNAL was completed with the June number. The crudities and errors of the first volume have been to a great extent avoided in the second. This second volume is also about thirty per cent. larger than the first. It contains, with its three supplements and the index, a total of four hundred and fifty-two pages, while the issue of last year contained only three hundred and forty pages. The committee has carefully selected and reviewed all papers and communications which have appeared from time to time, and although the Society is not responsible for the opinions expressed by the writers of papers it has been our aim to eliminate as far as possible all utterances of a personal, political or objectionable character.

We have endeavored to present a *clean* JOURNAL, which would be acceptable to all and offensive to none. Believing that the organ of a State medical society should never be an instrument for personal exploitation, nor under the control of an individual (nor even under the control of a committee absolutely to use for personal advancement), we have sought the advice of our trustees, who really control the JOURNAL, and of others, and have endeavored to secure the cooperation of the county societies and of their individual members in order that the JOURNAL might be the mouthpiece of the WHOLE society and that the highest interest of our members and of the profession at large might be advanced and that our JOURNAL should be creditable to this—the oldest State Society in the country.

The expenses of the committee during the past year have been larger than those of the previous year, but the receipts have also been larger. We have expended for printing, stationery, postage, etc., \$1,681.32. There have been paid to the editor (three-quarters of a year's salary, etc.), \$552.26—a total of \$2,233.58. There have been received from advertisers \$960.93 and from the sales of JOURNALS \$14.09—a total of \$975.02. The difference between the total expenditures and the total receipts is \$1,258.56. There are some bills against the Society up to the first of June, amounting to about \$210, which have not yet been

presented. There are also due the Society for advertising up to the first of June \$465.67. If we add the former and deduct the latter we have \$1,002.89 as the net cost to the Society for journalizing its transactions during the past year.

Acting on the suggestion of a number of members from different parts of the State it was decided to publish an alphabetical list, in addition to the regular county society list, of all the members in the State and this was presented in the supplement to the September number.

Your committee has not sought to force the JOURNAL into the commercial field. We have invited and accepted and shall continue to seek worthy advertisers who may deem the circulation of our JOURNAL to be advantageous to them; but we consider it beneath the dignity of the Medical Society of New Jersey to truckle to advertisers or seek to journalize for its pecuniary emolument. We have made it the object of the JOURNAL to convey to our members all the proceedings of our annual meeting with such other papers, news items and observations as might be of general interest and to pay the cost, the *whole* cost, if necessary, rather than enter into the disturbing realm of commercial journalism or barter our honorable inheritance for a mess of advertising.

The pages of many medical journals are disgracefully marred by the display of nostrums in their advertising columns. Far better go to their patrons without a single page of advertising and pay the entire cost of the issue rather than stultify their teachings and tarnish their good name for the sake of a few paltry dollars. May our JOURNAL always maintain the principles which have hitherto guided it and which will lead to safe and honorable eminence.

CHAS. J. KIPP,

D. C. ENGLISH,

WM. J. CHANDLER, *Chairman*.

Chairman:—It has been moved and seconded that this report be received and that a vote of thanks be extended to the committee for its successful work. Carried.

REPORT OF THE JUDICIAL COUNCIL.

To the President and Members of the Medical Society of New Jersey:

Your Board of Councilors begs to submit the following report:

A meeting of the Council was held in Trenton on the third day of November, 1905, at which meeting reorganization was effected and after disposing of miscellaneous business the Council adopted the following recommendations to be presented by each member of the board to the respective component societies in their districts:

First. The Council recommends that each County Medical Society be requested to establish a program committee, whose duty it shall be to prepare and announce at each meeting a program for the next following meeting.

Second. That each component society shall encourage the exchange of papers from time to time with neighboring component societies, and particularly so where there are local subjects of common interest which may be discussed with profit between the members of the local societies.

Third. That each component society appoint or elect, as they may choose, an abstracting com-

mittee, the duty of which shall be to keep the society informed of the progress in medicine and surgery, so far as they are able, and to report to the society any interesting discussions noted in the current literature which may bear upon questions of medical interest.

Fourth. That the reporter in each component society be requested to furnish a brief minute of each meeting of his society to the State Journal, which minute should include the discussions as well as abstracts of the papers.

Fifth. That the secretary of each component society be requested to furnish to the secretary of the Board of Councilors, thirty days before the annual meeting of the State Society, a memorandum of the number of contract practitioners who are members of his said society, and also the number of practitioners in said county who are not members of the said society.

Sixth. That each component society be requested to arrange for at least one semi-public meeting, to which the representative people of the community shall be invited, and at which meeting the program shall be so arranged that special orators shall discuss questions of medico-social and allied interests.

Commenting upon these various recommendations, it is obvious that if carried out with the spirit and method recommended by the Council there can be no question as to the far-reaching influence upon the future of each society.

Referring to the same by numbers, the object of the first is to have the members of the society become acquainted with the program prior to the meeting, that they may take up any part of it which is of interest to them and give the same the thought and consideration which always adds interest, as well as accuracy, to the discussions.

No. 2. In exchanging papers between the neighboring societies, there is sure to follow a keener interest in local subjects than could be otherwise stimulated.

No. 3. There are a number of members in each component society whose circumstances are such that they will not permit of a very large expenditure in books, journals, etc.; hence, however, eager and interested they may be in the progress of medicine, their circumstances act as a natural handicap to their progress. Your Council intended by this recommendation to establish a sort of post-graduate teaching in each component society, which of itself should increase the interest to those who are thus situated, and certainly add materially to the knowledge of those whose good fortune it is to be able to provide themselves with the literature necessary to advance the knowledge of others.

No. 4. Hitherto, the reports from the different component societies, with few exceptions, have not been of a character to stimulate particular interest nor have they shown any special thought on the part of the reporter. Your Council felt that both conditions might be well met if the society made it requisite on the part of this officer to send to the State Journal a minute of the meeting as it occurred, and such a requirement would in turn react upon the society and encourage it to provide a program of more than local interest.

No. 5. The question of contract practice is one that interests others than our local societies. It is at this time well known to all of you that component societies in different states, as well as the State societies, are taking decided action upon this as well as upon other similar questions.

Before making any particular recommendation upon this subject, your Council felt that it would be well to obtain some definite knowledge as to the number, etc., and it is creditable to the State of New Jersey that, so far as we have been able to collect the data in Atlantic County, there are at present only three physicians engaged in this mode of practice—two are members of our State Society and one is not.

The advisability of the sixth and last recommendation has been considered open to question. However, your Council, in weighing the interests on both sides, so far as appeared to them, decided that such a meeting, whilst of interest to the public, was of greater interest to the physician. Without entering into discussion of the same, it is perhaps sufficient to say that the profession up to this time has been rather "close communioned," so to speak. Doubtless, had the profession taken the public more into its confidence, letting it understand that its greatest object and interest was in the upbuilding and protection of the health of the community, there would be less opposition to the various proposals and movements recommended by the profession, and less supposed need for the various schisms and charlatanism with which the profession has to contend to-day. Too much stress cannot be laid upon a recommendation which has for its purpose the education of the public in questions of medico-social and allied interests.

Your Council has urged the societies in their respective districts to consider these various recommendations seriously, and to adopt them in so far as they seem to be suited to their needs and requirements.

It has been thought best to embody in the chairman's report the individual reports as given by the Councilor of each district; hence, your attention is now directed to that part of the general report.

REPORT OF THE COUNCILOR OF THE FIRST DISTRICT.

THOMAS W. HARVEY, ORANGE.

The Councilor of the First District would respectfully report that he has been able to visit but two societies of his district this year—Essex and Sussex.

No notice was received of the meeting of the Morris County, and the one meeting of the year held by Warren County was on the same date as the meeting of Sussex County.

The Essex County Medical Society has arranged for four meetings in the year. These meetings will be regular business meetings, and not merely scientific meetings.

The society adopted anti-contract practice resolutions similar to those adopted by the Atlantic County Society last year.

Respectfully submitted,

THOMAS W. HARVEY.

May 26th, 1906.

Philip Marvel, M. D., Chairman of Board of Councilors, New Jersey State Medical Society;

I visited during the past year the Somerset, Middlesex, Hunterdon and Mercer County Medical Societies and have laid before them the propositions made by the Board of Councilors at its meeting held in Trenton in the early part of the present spring.

The suggestions were received with favor by

all the societies mentioned, and no doubt will be acted upon in the near future.

The so-called system of "contract practice" has been abolished in all of these four county societies. The meetings I attended were extremely interesting and gave evidence of the progress and the general elevation of the standard of the medical profession. Yours very truly,

WM. A. CLARK.

Philip Marvel, M. D., Chairman of Board of Councilors:

My report as councilor for the fourth district will be brief, owing to the fact that I did not receive any notice of the meetings of the Monmouth County Medical Society, and only one notice from Ocean and Burlington County Societies. It so happened that I had to be away the day the Ocean County Society met and could not attend.

Wednesday, April 4th, 1906, I met with the Burlington County Society at Beverly. This was a very interesting and profitable meeting. Three excellent papers were read on tuberculosis and freely discussed. I explained the duties and recommendations of the Board of Councilors and found the first four or five recommendations were being pretty generally practiced.

The sixth, referring to the question of contract practice, was discussed, and a committee appointed to investigate and report at the next meeting of their society.

I have attended all the meetings of the Camden County Medical Society and presented the recommendations of the board to the members. The first five are being generally observed and practiced. The question of contract practice has not as yet received much serious consideration. Quite a number of our members are under contract in various ways, and to them it is a question they care very little to discuss.

It is a growing evil, especially in the larger towns and cities, and should receive continued and decisive action.

Camden County has three business and one social meeting annually, all well attended and full of interest. Respectfully submitted,

WM. H. ISZARD, M. D.

Camden, N. J., May 18th, 1906.

Your Councilor of the Fifth District has visited the counties of Atlantic, Cumberland, Cape May, Gloucester and Salem, and found the membership both active and increasing. The interest manifest in the meetings has certainly been of a complimentary character.

Especial mention may be made of Cape May and Salem Societies, where the interest in the meetings seems to have been materially increased.

In Cape May County the meetings, which have hitherto been held bi-yearly, will hereafter be held quarterly.

The character of the papers and discussions was worthy of mention, and in various ways the interests of all the societies in this district seem to be much stimulated and the spirit of reorganization seems to have been favorably received.

Respectfully submitted,

PHILIP MARVEL.

Atlantic City, N. J., May 18th, 1906.

To add further to the recommendations pre-

sented to the respective component societies your council would recommend to the House of Delegates and members of the Medical Society of New Jersey that a change in the date of the annual meeting be made from the second to the third Tuesday in June or September, so that the annual meetings of the State Society shall occur at a time when it will conflict as little as possible with the annual commencements of the different colleges and educational institutions in the State with which a number of our members are in one way or another connected, and also with the legally appointed meeting of the Board of Medical Examiners, whose attendance is also prevented at our annual meeting; and that the annual meeting of the American Medical Association, which usually meets the first week in June and when meeting in this State, which it is likely to do much more frequently hereafter, will exercise no little influence upon the number in attendance at the annual meeting of the State Society, when the meetings of the two associations occur so close together.

Your Council would also suggest that your editor and the Committee on Publication be further assisted in their labor of making our Journal even more interesting and helpful to its members than now, by the appointment of a board of ten or twelve collaborators, upon whom shall rest the responsibility of assisting, either by direct contribution or by soliciting contributions on subjects of medical interest, pertinent to the advance which is being made in the various branches of medical science to-day. As little can be accomplished without the conception of a definite plan or some distinct method by which that plan may become available, your Council believes its greatest duty will be best fulfilled; and its highest obligation discharged, by creating among the members of the component societies a proper appreciation of the responsibility of a membership in our State Society and stimulating in them a more than ordinary scientific interest, which will sooner or later lead to a healthful rivalry between its members in medical advancement and which shall finally result in placing the Medical Society of the State of New Jersey among the best organized and most progressive in its advancement of the societies composing the National Association.

How well this plan has been selected and the methods adapted to the work to be done must be judged by the society in the future. It is clear from the foregoing reports that the opportunity offered your Council has been employed, though perhaps in a feeble way, with pure motives and a keen interest for the Society's welfare, and that a more active and progressive medical body shall be the reward of their efforts is the earnest desire of your Board of Councilors.

Respectfully submitted,

T. W. HARVEY,

J. L. LEAL,

W. H. ISZARD,

WM. A. CLARK,

PHILIP MARVEL (Chairman).

Chairman:—I think that scant attention has been paid to these recommendations. I cannot see how the members can leave the room while the Society is in session. It is discourteous; we should have a full attendance at the sessions of the House of Delegates.

Dr. Halsey:—I move that the report be received and a vote of thanks be tendered to the men for the work they have done during the past year. Seconded. Carried.

Dr. Davis:—I think that the recommendations should be approved.

Dr. Schauffer:—It seems to me that the recommendations should be discussed as thoroughly as possible.

Dr. Chandler:—I wish to say a word concerning two of these recommendations. The first one relates to the time of the annual meeting. The Nominating Committee and the Board of Trustees should consider this; it should not be fixed invariably for one particular time of the year.

With regard to the second point, the appointment of collaborators on the JOURNAL, this is a good idea and one that I have advocated for some time, but if we leave this matter in the hands of the Board of Trustees it will receive proper attention. I move that we refer the recommendations to the Board of Trustees. Seconded.

Dr. English:—I second the motion regarding the time of the annual meeting; we cannot go away any week in June without conflicting with other and important engagements. It is a very difficult matter to fix now upon a time for next year's meeting and it should be decided on only after very careful consideration.

Chairman:—If I remember rightly some one suggested the second Wednesday in September.

Dr. Marvel:—It was not the intention of the Council that it should more than merely recommend the adoption of a date most generally convenient to the Society. It was recommended that the meeting should not occur concurrently with that of the State Board of Medical Examiners and other meetings. So far as the date is concerned it matters not. But some time should be found in which the greatest number of members could attend and yet not be deprived of attending other important meetings.

In Boston the American Medical Association planned to adopt the same course as the congress of American Physicians and Surgeons, that is, they meet in Washington once in every three years; the American Medical Association may meet triennially at Atlantic City. They also wish to have the meeting the same year. Therefore, these two meetings will occur close together and if we had our meeting at or about the same time it is probable that we would suffer from a lack of attendance.

Chairman:—The motion before the house is that the recommendations be referred to the Board of Trustees. Carried.

REPORT OF DELEGATES TO AND RECEPTION OF DELEGATES FROM OTHER SOCIETIES.

The Members of the House of Delegates of the Medical Society of New Jersey:

As your representatives to the American Medical Association we desire to make the following report:

New Jersey was represented by a full delegation—Dr. Charles J. Kipp, Dr. F. D. Gray, alternate for Dr. C. R. P. Fisher, and Dr. L. M. Halsey. We attended the meetings of the House of Delegates, and generally things were conducted expeditiously and smoothly.

There was some friction and criticism by a delegate from Washington on the action of Dr. McCormick in criticising the Oregon State Medical Society, and showing, through the Journal, its needs in the way of reform.

Dr. Vaughn criticised the secretary of the American Medical Association and the National Committee on Legislation for their action in opposing certain amendments which he prepared for the Pure Food Bill, claiming that this was done after a consultation with men who advised the course that he pursued, and with the partial sanction of the Department of Agriculture. On the other hand, the Committee on Legislation felt that if any amendments were necessary to the bill it should have come through them, which seems just and proper.

The Proprietary Association made a feeble attempt to oppose the course of the Journal in regard to proprietary medicines, but the House of Delegates nobly stood by the officers of the Association in the good work that they have been doing.

While we feel that the officers of the Association and the Board of Trustees should be commended for the good work they have been doing and the marked increase in the membership of the Association, yet there is certainly an undercurrent of sentiment that all matters of importance are discussed and settled before they are brought before the House of Delegates, which is generally so amenable a body that they readily concur. We are convinced that for the best interest of the medical profession of the United States that the entire proceedings and actions of the House of Delegates should be more open, as it would have a tendency to inspire more general confidence among the profession at large.

While the House of Delegates were remarkably well pleased with the results obtained, yet there was a marked feeling that nominations were decided upon previous to their presentation to the house, in a small caucus, and that the House of Delegates swallowed the bait. It is very evident to a close observer that ultimately this thing will act as a boomerang.

While we would not appear in the position of a fault-finder, yet we are satisfied it would be much better that the proceedings and financial report of the Board of Trustees should be laid before the House of Delegates in its entirety.

We were simply swamped in so far as entertainments were concerned. Boston certainly was lavish.

The attendance was larger than any in the history of the Association.

The section meetings were well attended, and the papers were more markedly scientific than those of any meeting that we have ever attended.

The Association voted to hold its next annual meeting at Atlantic City. We would say this action was taken without consulting your delegates. The meeting will probably be held in the latter part of May or early part of June. This will seriously interfere with the meeting of our State Society, and we would suggest that our annual meeting be held at a latter date than usual.

L. M. HALSEY,
F. D. GRAY,
CHARLES J. KIPP.

Chairman:—It has been moved and seconded that the report be received; what is your pleasure? Motion carried.

Dr. Hollingshead:—As no member has appeared from Burlington county, I wish to offer the name of Dr. G. T. Tracy as an alternate annual delegate from that county.

Chairman:—I make that appointment.

On motion, adjourned.

MEETING OF THE HOUSE OF DELEGATES.

TUESDAY AFTERNOON, JUNE 19, 1906.

Invocation was offered by the Rev. J. Holbrook Townsend.

ADDRESS OF WELCOME.

By. Dr. Thomas K. Reed.

MR. PRESIDENT, AND ALL OTHER MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY:—In the name of the local fraternity and our townspeople in general, I extend to you a cordial greeting. With an unerring sense of appreciation we know our friends; and, therefore, always look into the earnest faces of the doctors, when they come here, with gladness, gratitude and admiration. Your distinguished presence reminds us of the occasion when Cloverhouse spoke to the lords of convention:

"Unhook the west port and let us go free.
And so up with the bonnets of Bonnie Dundee."

An old hunter of my native town was asked if he were going on a certain gunning expedition after deer in the wilds of Atlantic County. "Me," he responded, in surprise, "Me? Why, I'm the main man!" And so when Atlantic City is mentioned, the doctors can say: Why, we are the main factor in creating this peerless health and pleasure resort! Then, if you please, you may strut around, metaphorically, and every one of you display the hundred eyes of Argus to the envious effulgence of the sun. You are aware that classical metaphors are a weakness of the medical profession and often the most blissful moment in a doctor's career is when he is given the chance to quote a little Latin.

We love the doctors and the sight of you warms our heart: in fact, the soul, anywhere that does

not love the doctors is as dark as the shadows that lurk in the halls of deep despair.

A young daughter, after hearing a carter lecture a refractory mule, explained to her mother that the man had told his mule lots and lots about religion. Now, I could tell you lots and lots about Atlantic City; but you will learn all you need to know of its charms and merits during your sojourn with us. Besides, your discoveries will be more pleasing than my inventions.

I will state, however, that we boast more especially of our climate. We live on climate. It is not the sand, but the climate that sells for five thousand dollars a running foot on the beach front, and yet, when the climatological society convened here a few weeks ago, it discussed everything under the sun but the salubrity of our unrivaled climate. The boardwalk may have allurements stronger than devotion to science. By the way, if you wish to cultivate a desire to stay on earth forever, come here in the bathing season and teach the mermaids how to float.

The dryness of our atmosphere is phenomenal. But, strange to say, though the air of the island is as dry as punk, the town has never gone dry. It may cheer you to learn that the municipality has made ample provision against the pangs of thirst. There is more than one oasis where the famished traveler can obtain liquid refreshment. Indeed, the usual order of nature is reversed, and among the fertile spots an occasional desert is found in the form of a Quaker hotel. Our teetotalers, however, are not as rigid as the individual who refused to drink water out of the Brandywine river. Nearly all imbibe rejuvenating moisture rather than risk mummification. Nevertheless we are a temperance people. The abundance of inspiring beverages apparently fosters moderation in their indulgence. Very few emulate the fish except to take the tide at its flood and to keep their heads up stream. For we are progressive. There is no one living here who believes that General Jackson is still President of the United States. All feel the divine impulse that is urging our country onward and upward to a purer and more resplendent civilization.

The seventeen-year locusts are ahead of you, and they prophesy war.

Is this convention the skirmish line of the heroic legions that are advancing to conquer and destroy the entire race of the ferocious and implacable mosquito? You will search in vain here for the anopheles species that carries malaria. You might as well look for an Ananias. Bear in mind, too, there are other bills than those of the mosquitoes; the landlord's, for instance. Then there may be a feminine bill presented in the moonlight when you are whispering in mellifluous tones, What are the wild waves saying, cousin—saying to thee?

The tree that bears the best fruit is the most clubbed. And it is perfectly natural that all the jokes ever invented anent the pestiferous insect should have been hurled at New Jersey. Even William Cullen Bryant sings of the tiny savage:

"Thou com'st from Jersey meadows, fresh and green.

The offspring of the gods though born on earth:
For Titan was thy sire, and fair was she
The ocean nymph that nursed thy infancy."

The closing line is ambiguous, a not unusual thing in versification. The poet must have mis-

taken Jersey girls bathing in the surf for ocean nymphs. Students of anatomy with their trained vision would have discerned the difference at a glance.

In discussing a means of sure death to the mosquito, sulphur, paregoric, formaldehyde and the zippy, zoomy, zizzy music of the beer-garden were named. The conclusion of the writer's views was as follows:

"But why prolong the agony? Why finish out the list?
It's safe to bet he's dead if you have slapped him on the wrist."

Merely a brief residence in Atlantic City is such an enviable privilege that minor offences and misdemeanors are punished by banishment. A justice of the peace says skiddoo to the culprit, and he is given a choice to leave town or to spend thirty days in the county jail.

The breezes from the sea are laden with nascent oxygen; and ozone, as you know, favors hilarity and extravagance. A lady visitor said to a fisherman: "The waves are so life-like." "Yes," he replied, "they come to the shore in great style and go away broke."

We have here not only the marvels of the land and sea, but the Marvels of Medicine—spelled with a big M.

Medicine is the noblest of the professions. It is a conservative force in peace and the redeeming feature of war. Doctors are slow to yield to a madness in the air. Their sterling virtues and common sense resist an epidemic of detraction and defamation. They stand firm and imperious for what is fair and just and reasonable; in truth, medicine is practical charity, and in your quest of knowledge you toil for humanity. Your vocation is one of self-sacrifice—an anchor of help and hope to afflicted mortals and a consolation to every stricken home.

In conclusion, may the spirit of the Great Physician, in its beauty and power, direct and reinforce your deliberations!

Everybody welcomes you!

Chairman:—Inasmuch as the doctors love Atlantic City, Atlantic City loves the doctors and it is always profitable and delightful to meet here. The doctors of Atlantic City have always given us a hearty welcome and have inspired a desire to come again. In behalf of the Society and personally, I wish to thank them for their cordial reception.

Dr. Chandler announced the names of the Nominating Committee, as follows:

The Nominating Committee consists of the Fellows and one delegate from each of the component societies:

Atlantic County—William E. Darnall.
Bergen County—H. C. Neer.
Burlington County—E. Hollingshead.
Camden County—Daniel Strock.
Cumberland County—Ellsmore Stites.
Essex County—Edward J. Ill.
Gloucester County—James Hunter, Jr.
Hudson County—Hamilton Vreeland.
Middlesex County—H. H. Janeway.

Monmouth County—D. D. Hendrickson.
Morris County—John Walters.
Ocean County—W. G. Schaffler.
Passaic County—Robert M. Curtis.
Salem County—Henry Chavanne.
Somerset County—J. P. Hecht.
Sussex County—B. W. Ferguson.
Union County—E. B. Silvers.
Warren County—G. W. Cummins.

Dr. Taylor:—I move that the Nominating Committee meet at the close of this session. Seconded. Carried.

REPORT OF CORRESPONDING SECRETARY.

Dr. Strock:—There is but little to report. The duties of this office are not onerous. Since the members of this Society decided to issue the transactions in journal form there has been but little correspondence with this office. There has been an interchange of journals with our JOURNAL. But the actual duties of the office have been very light compared to those of a few years ago.

REPORT OF THE RECORDING SECRETARY.

To the Medical Society of New Jersey:

During the past year the membership of the county societies has undergone many changes. Twelve counties report losses of from one to seven members each; five counties report gains of from two to twenty-two members each; four counties report the same membership numerically as that of last year. Essex, with thirty-four new members, reports the greatest increase. Atlantic, with a net gain of ten members, is entitled to especial credit as showing the largest percentage of increase. Deaths, removals, resignations and (I regret to add) delinquencies account for the numerous losses, but these have been more than offset by the addition of new members. We have now a membership of 1,229, while last year we numbered 1,213.

If we examine the lists of "non-affiliating" physicians we see that there is room for considerable missionary work. There are between 800 and 900 regular physicians practicing in this State who are not included in the membership of the Medical Society of New Jersey. I doubt if there is a man in this room who does not know of from one to a dozen such physicians. They should be sought out, invited and persuaded to unite with their county medical societies. If each one goes home and exerts himself in this work, the result will be an unprecedented increase in our membership next year.

One feature of the gains of some of the county societies is worthy of comment. For the first time in the history of our Society graduates of Homeopathic and Eclectic schools have been admitted to membership in the county societies. This is permissible under our new by-laws, which make "reputable and legally registered physicians who practice, or agree to practice, non-sectarian medicine," eligible to membership in their respective county societies. While there is some opposition to this innovation, it is the conviction of a large number of our fellow members that this course of action will be effectual in removing the barriers between the various schools of medicine and

eventually unite all physicians into a grand, useful and harmonious organization.

This is the regularly appointed year for the general election of permanent delegates. Candidates have been presented from two component societies—Atlantic and Hudson. Bergen County was entitled to select two nominees, but none have been selected. Cape May was also entitled to select a nominee, but has not presented any. Hudson was entitled to select eight nominees. Only two have been presented. Notification of these privileges was given in the report of the recording secretary last year, in accordance with the requirements of the by-laws. Camden and Cumberland are entitled to fill each, one vacancy. Three permanent delegates have died during the past year—O. B. Gross, of Camden; O. H. Adams, of Vineland, and Peter V. P. Hewlett, of Newark. One, J. C. Applegate, of Cumberland County, has resigned.

The following permanent delegates have been absent from two consecutive annual meetings: M. K. Elmer, J. H. Bradshaw, R. P. Francis, G. F. Wilbur, James Douglass, J. M. Stewart, H. D. Van Gaasbeek, T. M. McLean, W. U. Selover and J. M. Reese.

Excuses satisfactory to the Councilors have been received from R. P. Francis and F. N. McLean, and their names are retained on the list.

The following delegates presented no excuses whatsoever: M. K. Elmer, J. H. Bradshaw, G. F. Wilbur, James Douglass, J. M. Stewart, H. D. Van Gaasbeek, W. U. Selover and J. M. Reese.

Their names are therefore dropped from the roll.

After removing these names and adding the names of those elected to-day, our roll of permanent delegates contains a total of 113.

Last year attention was especially called to the requirements of the by-laws regarding the sending of lists to the recording secretary. As a result the reports have been more complete and more promptly forwarded than ever before. Some county secretaries, however, have failed to send in all of the four reports or have failed to send them until after the appointed time. Failure in either of these requirements places the component society on the delinquent list and disqualifies all of its members from participation in the proceedings of this Society. Four component societies—Burlington, Hunterdon, Somerset and Warren—have failed to send in their reports as required in the by-laws, and three others, though technically tardy, were accepted only because the spirit was willing, but the flesh was weak in fulfilling the letter of the law.

There is generally no good reason for delinquency in sending these reports. Whenever there is, the Society will be lenient.

One month before the annual meeting is a minimum time in which to revise the lists, collate the names of delegates, reporters, etc., and arrange this material for the program sufficiently early to meet the convenience of the members of the Society. It is necessary, therefore, that promptness as well as completeness should characterize the returns from the component societies.

There are two matters concerning which there seems to be confusion in the minds of many of the members. One is the relation existing between the payment of dues to the State Society and subscriptions to the Journal. The other is the relation between the payment of county society dues and membership in the State Society.

(The term State Society is here used for the Medical Society of New Jersey). It is pretty generally understood that all members paying their assessments in advance receive the Journal regularly and without any additional payment therefor. The confusion arises mainly in the cases of new members, and is largely due to the variation in the fiscal years of the different component societies of the State Society and of the Journal.

The Journal year begins in July and includes the twelve issues from July to the following June. The State Society year runs from June to June. The component societies hold their annual meetings in six different months of the year, although the majority has fixed upon April or May as the most suitable time. The assessments for the State Society are paid annually and in advance. The assessment paid by a component society to the treasurer of the State Society in May pays the State Society dues for the certified members of that component society from June of that year to the June following. The payment of this assessment covers the subscriptions of these said members for the Journal from July of the same year to June of the following year, inclusive.

Members of one or two years' standing are not particularly disturbed by these variations in the fiscal year, but how is it with new members coming in at the annual meeting or at different times during the year? Perhaps this will be better understood if we illustrate by a concrete example. — component society holds its annual meeting in April, 1906. Four new members are received. They pay their dues at once for both the component and the State Societies. They are then members of the component society, but not necessarily of the State Society. In May, 1906, their State Society dues are forwarded to State Treasurer Dr. Mercer. This constitutes them members of the State Society on the day of our annual meeting and for one year thereafter, i. e., for one year beginning with to-day. It also entitles them to receive the Journal from July, 1906, to June, 1907, inclusive. Members who join this same component society in July next, or in December, 1906, pay the same dues for the State Society, and when those dues are forwarded to the treasurer of the State Society, and *not until then*, they are members in good standing, will be vouched for as such to the American Medical Association and will receive the Journal of this Society from July, 1906, to June, 1907, inclusive.

Some of the men who joined component societies last April and paid their full dues expected at once to receive the Journal and to be eligible to membership in the American Medical Association. A moment's reflection will show that this is an erroneous view. Last April was not a part of the fiscal year of the State Society for which these members paid their dues. It belonged to the year just passed, for which they paid no dues. If they wished to become members in good standing at once and be certified to the American Medical Association and also to receive the Journal of this Society, they should have paid also the dues of the State Society for the past fiscal year. Then, when these dues were received by the treasurer of the State Society, notice would have been immediately sent to the recording secretary, their names would have been entered at once on the list of members in good standing, they would have been certified as such to the American Medical Association and our Journal, including all

the issues for the Journal year, would have been sent to them.

I fear that I may have occupied too much of your time and perhaps have wearied you with what to some may seem like repetitions of needless details, but so many, even among those who ought to be well informed as to the methods of our Society, have been unwilling to give any opinion or have expressed such vague, confused or erroneous views on these matters that duty seemed to compel an explicit statement of facts. Changes in these rules have been suggested. In a few State Societies, where the annual dues are large, a rebate of one-half is made to members joining after the first six months. This seems hardly necessary in a Society like ours, where the annual dues are so exceedingly small.

Another year is added to the venerable age of our Society. Many observers would characterize its last twelve months as uneventful. But no such period is uneventful. While nothing of startling moment has transpired in the affairs of this Society, several movements have been conducted to a successful issue and others have been introduced and will call for calm and judicious consideration. The work of the different committees, especially that on legislation, the subject of fees for life insurance examinations, of contract practice, of proprietary medicines, etc., have enlisted general attention and emphasize more and more the need of organized effort on the part of the medical profession to protect the community as well as itself against the aggression of injustice and fraud. Our great national organization, backed by all of the State and County Societies, is educating the masses of the people, is taking steps to formulate sanitary and medical legislation and will eventually bring such an influence to bear upon our legislators as will be absolutely irresistible. Let us exert every effort to direct that influence so that it may be always for the RIGHT.

Chairman:—It has been moved and seconded that this report be received, approved and placed on file; what is your pleasure? Motion carried.

REPORT OF THE TREASURER.

This report was presented by the treasurer, Dr. Mercer, as follows:

The Medical Society of New Jersey in Account with Dr. A. Mercer, Treasurer.

June 22—Mercer County, additional payment for 1905.....	\$6.00
June 29—Burlington County, additional payment for 1905.....	8.00
June 29—Camden County, additional payment for 1905.....	2.00
July 1—Interest, Northern Pacific, Great Northern, Chicago, Burlington & Quincy coll. bds.	10.00
July 1—Interest, Chicago & Alton bonds.....	17.50
Aug. 1—Interest, N. Y. Central, Michigan Central coll. bonds.	17.50
Aug. 16—Atlantic County, additional payment for 1905.....	2.00
	<hr/>
	63.00

Brought forward.....	\$63.00
Oct. 1—Interest, Northern Pacific, Great Northern, Chicago, Burlington & Quincy coll. bds.	10.00
Nov. 25—Somerset County, additional payment for 1905.....	2.00
1906.	
Jan. 1—Interest, Northern Pacific, Great Northern, Chicago, Burlington & Quincy coll. bds.	10.00
Jan. 1—Interest, Chicago & Alton bonds.....	17.50
Jan. 20—Sale of Journals.....	2.95
Jan. 20—Advertisements in Journal	276.67
Feb. 1—Interest, New York Central, Michigan Central coll. bonds	17.50
Feb. 28—Advertisements in Journal	100.00
April 1—Interest, Northern Pacific, Great Northern, Chicago, Burlington & Quincy coll. bds.	10.00
	<hr/>
	\$509.62
May—Atlantic Co. assessment..	\$60.00
Bergen Co. assessment....	51.00
Burlington Co. assessment.	31.00
Camden Co. assessment..	80.00
Cape May Co. assessment.	20.00
Cumberland Co. assessment.	42.00
Essex Co. assessment....	290.00
Gloucester Co. assessment	25.00
Hudson Co. assessment..	148.00
Hunterdon Co. assessment.	25.00
Mercer Co. assessment....	66.00
Middlesex Co. assessment.	38.00
Monmouth Co. assessment.	41.00
Morris Co. assessment....	51.00
Ocean Co. assessment....	14.00
Passaic Co. assessment....	86.00
Salem Co. assessment....	19.00
Somerset Co. assessment..	20.00
Sussex Co. assessment....	17.00
Union Co. assessment....	81.00
Warren Co. assessment..	26.00
	<hr/>
	1,231.00
Dr. S. J. Wooley, Com. of Arrangements, 1905.....	\$73.75
	<hr/>
	\$73.75
Salem Co., for San Francisco Fund.....	\$20.00
Warren Co., for San Francisco Fund.....	36.00
Camden Co., for San Francisco Fund.....	47.70
Passaic Co., for San Francisco Fund.....	100.00
Burlington Co., for San Francisco Fund.....	45.00
Atlantic Co., for San Francisco Fund.....	68.00
Morris Co., for San Francisco Fund.....	54.00
Union Co., for San Francisco Fund.....	35.00
	<hr/>
	\$405.70
Cash balance in bank June 15, 1905....	\$4,013.39
\$1,000 bond North. Pac. and Gt. North., C. B. & Q. joint as cost.	\$972.50
\$1,000 bond Chi. & Alt. 3 1/2s cost.	786.25
\$1,000 bond N. Y. Cen., Mich. Cen. coll. 3 1/2s cost.....	912.50
	<hr/>
	\$2,671.25
	<hr/>
	\$8,904.71

1905.	CR.
June 22—Dr. W. J. Chandler, for Charters	\$30.56
June 22—Dr. W. J. Chandler, Recording Secretary.....	64.40
June 22—Dr. W. J. Chandler, Committee on Program.....	57.75
June 22—Dr. W. J. Chandler, Committee on Publication....	168.80
June 23—Dr. Archibald Mercer, Treasurer	12.21
June 26—Whitehead & Hoag, badges	55.01
June 30—Dr. Charles Young, Chairman Com. Legislation...	55.12
July 14—Dr. E. Franklin Smith, Stenographer	65.00
Aug. 2—Fidelity & Casualty Co., Treasurer's Bond.....	15.00
Aug. 2—Dr. W. J. Chandler, Recording Secretary	69.05
Aug. 2—Dr. Philip Marvel.....	21.21
Aug. 2—Dr. W. J. Chandler, Committee on Publication....	204.75
Aug. 2—Hardham Printing Co.,	44.00
Sept. 6—Dr. W. J. Chandler, Committee on Publication....	103.03
Sept. 14—Dr. W. J. Chandler, Committee on Publication....	185.79
Oct. 16—Dr. R. C. Newton, salary and expenses.....	136.40
Oct. 16—Dr. W. J. Chandler, Committee on Publication....	185.71
Nov. 16—Dr. W. J. Chandler, Committee on Publication....	108.51
1906.	
Jan. 3—Dr. W. J. Chandler, Committee on Publication ...	128.28
Jan. 20—Dr. W. J. Chandler Com. Pub. \$277.37, Sec. \$114.05	391.42
Feb. 24—Dr. W. J. Chandler, Committee on Publication....	115.39
March 12—Dr. W. J. Chandler, Committee on Publication....	299.15
April 17—Dr. W. J. Chandler, Committee on Publication....	296.11
May 17—Dr. W. J. Chandler, Committee on Publication....	104.29
May 17—Dr. W. J. Chandler, Recording Secretary.....	133.11
	<hr/> \$3,050.05
Cash balance in bank June 13, 1906.....	\$3,183.41
\$1,000 bond Nor. Pac., Gt. Nor., C. B. & Q. joint 4s, cost ...	\$972.50
\$1,000 bond Chi. & Alton 3½s, cost	786.25
\$1,000 bond N. Y. Cen., Mich. Cen. coll., cost.....	912.50
	<hr/> \$2,671.25
	<hr/> \$8,904.71

Chairman:—Regarding the San Francisco fund, it is unnecessary for me to tell you of the great needs of the profession there at this time. A short time ago, I took it upon myself as Acting President to address a letter to the Secretary of our Society, and asked him to send a copy of the secretaries of the County Societies, with the request that they send it to each individ-

ual member of their Society, asking for contributions for the relief of the profession in San Francisco.

My thought was to give each member of our Society an opportunity to contribute something to a special fund for our medical brothers in distress.

I am disappointed in the result, to think of this ancient and honorable Society, with a membership of over 1,200, contributing less than \$500.

I expect that every member has already given something to the San Francisco fund, perhaps some have contributed a number of times, and through many different channels, but granting that you have done this, it does not relieve you of a responsibility owing your brothers in distress, and I hope that every member of this Society, who has not already done so, will forward to our treasurer some contribution for this particular work, and I am sure you will not only receive the grateful thanks of the ones in need, but what is far better, you will have the satisfaction of an approving conscience.

It has been moved and seconded that Dr. Mercer's report be received and placed on file. What is your pleasure?

Motion carried.

Dr. Kipp:—A committee has been appointed to audit the accounts of the Treasurer and Dr. Fisher reports that these accounts have been examined and found to be correct and the vouchers properly kept.

REPORT OF THE BOARD OF TRUSTEES.

Dr. Kipp:—At last year's meeting a prize of one hundred dollars (\$100.00) was offered for the best essay on pneumonia, etc., but no essays have been presented. The Board of Trustees, therefore, recommend that the same prize of one hundred dollars (\$100.00) be again offered, the subject of the essay to be the same, that is, "Pneumonia, Its Etiology, Symptomatology and Treatment."

Dr. Kipp further reported the re-election of Chairman Kipp and Secretary English as board officers; English, Elmer, Mitchell and Chandler as Finance Committee, and Kipp, English and Johnson as Prize Essay Committee.

The board has received report of treasurer, showing balance on hand, \$3,183.41; that treasurer has been directed to furnish bond for ensuing year for same amount as heretofore. He also reported the good work done by the Committee on Publication, whose report had been read and approved, and for which they received the thanks of the board; also referred to the excellent work of the Committee on Legislation, which had required a large amount of time and considerable expenditure of money; that this was approved

and the committee was authorized to spend the coming year, if similar work was required, an amount not exceeding \$500. Dr. Kipp referred especially to the committee's success in preventing the passage of the Osteopathic bill against the determined efforts of its advocates.

Chairman:—It has been moved and seconded that the report of the Board of Trustees be received and placed on file. Carried.

MISCELLANEOUS BUSINESS.

Dr. Baldwin:—I wish to introduce the following resolution:

Resolved, That hereafter, whenever vacancies in the regular school of medicine occur on the State Board of Medical Examiners, the same shall be filled by nominees recommended by this Society.

Dr. Kipp:—I move that this resolution be referred to the Business Committee and that they report at the next meeting of the House of Delegates. Seconded. Carried.

Chairman:—The County of Essex not being represented by annual delegates in the House of Delegates, I will, by request, appoint Dr. Worl, Dr. Buerman and Dr. Emerson as alternate delegates.

Dr. Schauffler:—Following the custom of other medical societies, "I move that the Medical Society of New Jersey assume the cost of medical defense of its members."

Dr. Ard:—I wish to second that motion. It seems to me that while I have not given this subject much consideration it is an important one. I recently knew of a case where the doctor was put to a great deal of expense in defending a suit, but he finally won out. Nevertheless he had no redress so far as money expenses were concerned. There may be many members of this Society who are able to defend their own suits, but there are some who cannot. I think this idea of defense of the medical members a good one.

Dr. Lampson:—I move that this resolution be referred to the Committee on Business and for them to report. Seconded.

Dr. Chambers:—This is a new point to me but for about ten dollars (\$10.00) an accident insurance company will insure you against malpractice suits. I do not think it would be a bad policy to let such a company do this business rather than that we should undertake it.

Chairman:—It has been moved and seconded that this matter be referred to the Business Committee with instructions that they report at the next meeting of the House of Delegates. Carried.

A motion to adjourn was made and carried.

Chairman:—The motion to adjourn has been seconded and carried. The House of Delegates stands adjourned, and we will now convene in general session.

The following papers* were then read and discussed:

"The Tendency of the Organism to Limit Pulmonary Tuberculosis."—Theodore Senseman, Atlantic City.

"A Case of Oedema of the Larynx."—F. C. Ard, Plainfield. Discussion opened by N. L. Wilson and T. R. Chambers.

"The Prevention of Scarlatinal Nephritis."—Floy McEwen, Newark.

"Examination of Eyes and Ears of School Children."—Linn Emerson, Orange. Discussion opened by N. L. Wilson, Elizabeth, and T. R. Chambers, Jersey City.

Adjourned at 6 P. M.

FIRST DAY—TUESDAY, JUNE 19TH.

GENERAL SESSION.

EVENING SESSION—8 P. M.

Annual address by the Third Vice President, David St. John, Hackensack. "The Value of Tartar Emetic in the Treatment of Traumatic Tetanus and Cerebro-Spinal Meningitis."

"The System of Medical School Inspection of the Department of Health of the City of New York."—Thomas Darlington, Commissioner of Health, New York.

Oration in Surgery.—Thomas W. Harvey, Orange.

Oration in Medicine.—"The Study of Structure and Function in its Relation to Practical Medicine."—Joseph Tomlinson, Bridgeton.

By special permission, Dr. Balleray was permitted to read his paper which had been omitted owing to his absence from the afternoon session.

"Fibroid Tumors of the Uterus."—George H. Balleray, Paterson.

Discussion opened by Edward J. Ill, Newark, and G. K. Dickinson, Jersey City.

On motion, adjourned.

SECOND DAY,

WEDNESDAY, JUNE 20TH.

MORNING SESSION—9 A. M.

GENERAL SESSION.

"Metastatic Panophthalmitis."—Charles J. Kipp, Newark.

* These papers will appear in the JOURNAL.

Discussion opened by W. B. Johnson, Paterson, and continued by Drs. Sutphen and N. L. Wilson.

Chairman.—It has been moved and seconded that Dr. P. A. Harris, of Paterson, present his pathological report now. Carried.

At our meeting one year ago Dr. Staehlin read a paper upon "Tubal Pregnancy." At his request I opened the discussion upon his paper. With his permission I presented eight specimens of unruptured tubal pregnancy, mainly to show that such cases generally exhibited symptoms by which a diagnosis might be made and the patient relieved by operation, prior to the occurrence of the graver consequences of that condition.

The eight women from whom gravid fallopian tubes were removed had all presented symptoms which led to the diagnosis of tubal pregnancy. They were all operated on by supra-pubic abdominal section. Their abdominal cavities all contained blood in varying quantities. All of the patients recovered from their operations and were cured.

One of the physicians in discussing my report of these cases spoke as follows:

"I should like to ask Dr. Harris a question regarding the specimens he presented which were supposed to be those of an unruptured tubal pregnancy; what evidence does he present that these were really such cases? The specimens that have been passed present no positive evidences at all of such a condition. Some of these specimens might be filled with inspissated pus, or, even, as a gentleman on my right facetiously remarked, 'Stuffed with cotton.' Dr. Harris has failed to produce the *corpus delictum* and the old Scotch verdict, '*not proven*,' applies to his cases."

In answering this member I then said that if he wished it, I would be glad to secure microscopic diagnosis of these cases, and report it to our Society at our next meeting.

The more I pondered on the concluding remarks of this member, the more I became convinced that he himself seriously doubted the genuineness of the specimens which I had presented to the Society.

When the meeting was over, and while at the hotel, I packed my eight specimens of tubal pregnancy in a wooden box and expressed them to my office in Paterson. As soon as possible after my return I sent for Dr. Frank R. Sandt, our pathologist. When he reached my office I told him of the fate of my specimens, and informed him that I wished him to open the box, remove the specimens, take a description of each, number and label the specimens, and place his private seal upon the cover of every bottle, all of which he at once did. Later I asked this member of the Society if he would accept the microscopical diagnosis of Dr. Sandt, the official pathologist of the Paterson General Hospital. He told me he would. The specimens were therefore submitted to Dr. Sandt for his microscopical report and diagnosis. I now have in hand the report of Dr. Sandt, which I will read to you:

"Paterson, N. J., June 16, 1906.

"P. A. Harris, M. D., Paterson, N. J.

"Dear Doctor:—I beg to present the following report on the examination of the eight tubes that you submitted to me for microscopical diagnosis:

"Case No. 1. Hillman. Operated 25 days after the beginning of the last menstruation. Size of tube $2 \times 1\frac{1}{4}$ inches. Chorionic villi were found throughout the stained sections which were diagnostic of tubal pregnancy.

"Case No. 2. Eckert. Operated March 16, 1902. Size of tube $1\frac{1}{2} \times 1$ inch. Sections show a tube distended with blood, at the periphery of the tube some cross sections of villi were found. Trophoblastic cells were also found in different areas of the sections. Diagnosis: Tubal pregnancy.

"Case No. 3. Garbaccio. Operated 5 weeks after last menstruation. Size of tube $5\frac{1}{2} \times 3\frac{1}{4}$ of an inch. Sections from the central portion of the tube show chorionic villi, syncytial cells and trophoblastic cells. Diagnosis: Tubal pregnancy.

"Case No. 4. Cohn. Operated 6 weeks after the last menstruation. Size of tube $1\frac{1}{2} \times 3\frac{1}{4}$ inches. Sections show a few villi covered with syncytial cells. Diagnosis: Tubal pregnancy.

"Case No. 5. Gartland. Operated 10 weeks after the last menstruation. Size of tube, $2\frac{1}{2} \times 3\frac{1}{4}$ inches. Trophoblastic cells and chorionic villi were found in the specimens. Diagnosis: Tubal pregnancy.

"Case No. 6. Randall. Operated 8 weeks after last menstruation. Size of tube, $3\frac{1}{2} \times 2$ inches. After hardening the tube in mass, gross section about one-half inch in thickness were made preparatory to embedding. While making these sections a gestation sac was opened and an embryo was found attached to the wall of the sac by means of a well developed umbilical cord. The embryo was so far advanced that the fingers and toes were well developed. No microscopical examination was made, as none was needed to establish the diagnosis of tubal pregnancy.

"Case No. 7. Wells. Size of tube $2 \times 1\frac{1}{3}$ inches. This tube had a soft cystic portion near the fimbriated extremity and a section through this area opened up a gestation sac containing a small embryo about 3-16 of an inch long. The head and face are easily distinguished but the arms and legs are still represented by their respective buds. No microscopical examination was needed to establish the diagnosis of tubal pregnancy.

"Case No. 8. McG. Tube $4 \times 1\frac{1}{2}$ inches in size. Removed 60 days after last menstruation. Central portion of the tube was cystic to the touch. Sections through this area revealed a large cavity with an embryo about $\frac{3}{4}$ of an inch long in each end. Both embryos were well developed, the fingers and toes on each being very distinct. Certainly no further examination was necessary to establish the diagnosis of a twin tubal pregnancy.

"In conclusion, then, I can report that all of the eight cases are tubal pregnancies. Embryos were found in three cases and in the remaining five the diagnosis was based on the finding of chorionic villi, syncytial cells and trophoblastic cells.

"Very truly yours,

"FRANK R. SANDT."

"Paterson, N. J., June 18th, 1906.

"P. A. Harris, M. D., Paterson, N. J.

"Dear Doctor:—To-day, June 18th, 1906, I submitted to Dr. Samuel Wyllis Bandler, of New York City, the microscopical slides of Case No. 1 (Hillman), No. 2 (Eckert), No. 3 (Garbaccio), No. 4 (Cohn), and No. 5 (Gartland). After examining the same Dr. Bandler pronounced all of them to be cases of tubal pregnancy. He based his diagnosis in each case on the finding of chorionic villi and syncytial cells. Several days ago I mailed to Dr. J. Withridge Williams, of Baltimore, Md., specimens from these same cases and I hope that his opinion will be in your hands by Tuesday, June 19th, 1906.

"Very truly yours,

"FRANK R. SANDT."

"Baltimore, June 18, 1906.

"Dr. Philander A. Harris,

"Hotel Chelsea, Atlantic City, N. J.

"My Dear Doctor Harris:—I have looked over the five specimens of extrauterine pregnancy which you sent me. In each instance you have to do with a tubal mole, concerning whose origin there can be no doubt. Possibly you may gain the information you desire from the following brief notes:

"Case 4. Cohn. In this case the product of conception was attached to the tube wall near the mesosalpinx. It was walled off from the lumen of the tube by a fairly complete capsular membrane. Within the blood clot are numerous definite villi, but no trace of a distinct ovum. There are likewise many haematin crystals. There is no decidua at the site of implantation, nor any trace of trophoblastic cells invading the tube wall.

"Case 3. Garbaccio. In this specimen the attachment of the ovum was apparently opposite to the mesosalpinx. The tubal lumen is reduced to a mere slit, from which the product of conception is separated by a short but definite capsular membrane, the greater part of the ovum being in direct contact with the muscular tissue of the tube. There is no trace of an embryo, but there are many typical villi and masses of chorionic cells, which in numerous places have deeply invaded the tube wall. At one point a large vein can be seen, whose walls have been perforated by the invading foetal cells. There are no signs of decidua. There is slight inflammation of the peripheral part of the tube and considerable proliferation of the peritoneal endothelium.

"Case 2. Eckart. This is a typical tubal mole, with an imperfect capsular membrane and very few villi. No trophoblastic cells or decidua can be seen in the tube walls. No signs of inflammation.

"Case 5. Gartland. This is exactly identical with the above, except that the primary attachment of the ovum was probably opposite to the mesosalpinx.

"Case 1. Hillman. This is a typical mole which contains very few villi, which are markedly degenerated. As very little tube wall has been retained in the specimen, it is impossible to make any statement as to the condition of the capsular membrane or the presence of decidua or trophoblastic cells in the tube wall.

"Hoping that this will be all the information that you require, I am

"Yours sincerely,

"J. WITHRIDGE WILLIAMS."

I must confess that I was annoyed by the concluding remarks of this member. In my opinion

they seriously reflected on either my intelligence, or my integrity, possibly both, but my personal feelings are of little consequence compared with the importance of knowing beyond the shadow of a doubt the real nature of the tubes which I exhibited.

With this report I trust that the matter will be closed and that I shall be given proper credit for the presentation of these specimens of unruptured tubal pregnancy, which through the humorous and unfair remarks of the member referred to, may have been regarded by some as fake specimens of ectopic gestation.

PHILANDER A. HARRIS.

Chairman:—Dr. Synnott and Dr. T. N. Gray are appointed alternate annual delegates from Essex county.

Chairman:—It has been moved and seconded that Dr. Noble, of Philadelphia, Dr. Leszynsky, of New York, Dr. Daland, of Philadelphia, be invited to sit with us and take part in the discussion. Carried.

Chairman:—I will appoint as alternate annual delegates from Passaic County, Dr. William H. Carroll and Dr. F. F. C. Demarest, of Passaic.

SYMPOSIUM ON NUTRITION DURING FIRST FIRST YEAR.

(a) Universal failure of maternal feeding. (b) Breast feeding, how best conserved. (c) Principles of infant feeding. (d) Methods of substitute feeding, empirical, commercial, mechanical, mathematical natural or rational. (e) Proximate factors in the nutrition of infants.—Henry L. Coit, Newark.

Digestion of Fats, Proteids and Carbohydrates in the first year.—J. Finley Bell, Englewood.

Suitable diet during the second year.—Margaret P. Brewster, Grantwood.

Disorders of digestion in the second year.—Alexander McAlister, Camden.

"The Etiology of Rachitis, Scorbutus and Cretinism."—August A. Strasser, Arlington.

"Diarrhoea in Infancy and Early Life."—Irwin H. Hance, Lakewood.

Discussion opened by H. L. Coit, Newark. "Some Dietetic Errors and Their Effects."—W. Blair Stewart, Atlantic City.

Discussion opened by Philip Marvel, Atlantic City and W. E. Darnell, Atlantic City.

"A Brief Study of the Clinical Evidence of Some Infections that Apparently Enter the System through the Faucial Tonsils."—Philip Marvel, Atlantic City.

Discussion opened by W. Blair Stewart, Atlantic City.

On motion, adjourned.

MEETING OF THE HOUSE OF DELEGATES.

Wednesday Afternoon June 20th—Report of Nominating Committee.

Dr. D. C. English:—I want to state that the meeting of the Nominating Committee yesterday afternoon was one of the most pleasant, harmonious and expeditious sessions it has ever been my privilege to attend. There was considerable discussion on the time and place of the annual meeting; but we thoroughly canvassed this question and came to the conclusions stated in our recommendations. I will now call upon Dr. Strock, secretary of the Nominating Committee, to read the report.

Dr. Strock read as follows:

The Committee on Nominations met yesterday afternoon and organized by the election of David C. English as chairman and Daniel Strock as secretary. The following nominations were unanimously made:

President—ALEXANDER MARCY, JR., Riverton.

First Vice-President—EDWARD J. ILL, Newark.

Second Vice-President—DAVID ST. JOHN, Hackensack.

Third Vice-President—BENJAMIN A. WADDINGTON, Salem.

Corresponding Secretary—DANIEL STROCK, Camden.

Recording Secretary—WILLIAM J. CHANDLER, South Orange.

Treasurer—ARCHIBALD MERCER, Newark.

Councillors—First District, THOMAS W. HARVEY, Orange; Second District, JOHN L. LEAL, Paterson; Third District, WILLIAM A. CLARK, Trenton; Fourth District, WILLIAM H. ISZARD, Camden; Fifth District, PHILIP MARVEL, Atlantic City.

Committee on Publication—DAVID C. ENGLISH, New Brunswick; CHARLES J. KIPP, Newark.

Committee on Scientific Work—NORTON L. WILSON, Elizabeth.

Committee on Public Hygiene and Legislation—HENRY H. DAVIS, Camden (term expires 1907); WILLIAM G. SCHAUFFLER, Lakewood, (term expires 1909); FRANK D. GRAY, Jersey City, (term expires 1909).

Committee on Arrangements—PAUL M. MEGRAY, Camden; JAMES MEGRAY, Cape May; VIRGIL M. D. MARCY, JR., Cape May; E. L. B. GODFREY, Camden; JOS. TOMLINSON, Bridgeton; ENOCH HOLLINGSHEAD, Pemberton.

Committee on Programme—ALEXANDER MCALISTER, Camden, (term expires 1908).

Delegate to the Amer. Med. Ass'n—LUTHER M. HALSEY, Williamstown, (term expires 1908).

Alternate Delegates to A. M. A.—H. GENET TAYLOR, Camden; EDWARD J. ILL, Newark; GEORGE E. READING, Woodbury.

Delegates to Pennsylvania State Society—HARRY A. STOUT, Wenonah; W. BLAIR STEWART, Atlantic City; WILLIAM A. DAVIS, Camden.

New York State Medical Society—WILLIAM J. CHANDLER, South Orange; JOSEPH S. BAER, Cam-

den; HOWARD A. WILSON, Woodbury; WALTER REYNOLDS, Atlantic City.

Connecticut Medical Society—SAMUEL A. HELLER, Hoboken; HENRY CHAVANNE, Salem; JOHN C. PARSONS, Jersey City.

Maryland State Society—WILLIAM A. CLARK, Trenton; GEORGE H. BALLERAY, Paterson; MARY E. GASTON, Somerville; EMMA M. RICHARDSON, Camden.

Massachusetts State Society—GORDON K. DICKINSON, Jersey City; THOMAS N. GRAY, East Orange; FRANK D. GRAY, Jersey City.

We recommend that the President be empowered to appoint as delegates to the Rhode Island, Delaware and Missouri State Societies and to the Mississippi Valley Medical Association, any members of our Society who shall signify their desire and willingness to attend the annual meetings of either of such organizations.

We also recommend Cape May as the place of the Society's annual meeting next year, and that the time of said meeting be during the last week in June.

Respectfully submitted.

DAVID C. ENGLISH, *Chairman.*

DANIEL STROCK, *Secretary.*

Dr. Norton L. Wilson, of Elizabeth:—I move that the nominations as presented by the secretary of the Nominating Committee be accepted with the exception of the name of Wilson, and, in his place, the name of Dr. Thomas N. Gray be inserted.

Chairman:—This motion is not seconded.

Chairman:—It is moved and seconded that the report of this committee be adopted. What is your pleasure?

Dr. David E. English:—I should like to say a word regarding the time and place of next meeting. The American Medical Association meets here next year and I think we ought to meet at the same place and during the same week if possible. It has been stated that under these circumstances our meeting is killed. But so far as that goes it will always be overshadowed by the meeting of the national association whenever held in this State. I am convinced that it would be more convenient to hold our meeting in the same place and at about the same time, that is, during the same week. I think it would be better to meet just before the American Medical Association so that the members elected for that meeting may become members of the American Medical Association without the payment of next year's dues.

Dr. David C. English:—I would suggest that the time and place of our next meeting be discussed after the election of officers and the appointment of committees.

Chairman:—The resolution before the House of Delegates is on the adoption of the report of the Nominating Committee.

Dr. Benjamin:—I move an amendment

separating the report; let us first vote upon that part having to do with the election of officers and committees and leave the second part of the report for further consideration. Seconded.

Chairman:—You have heard Dr. Benjamin's amendment; what is your pleasure?

Amendment carried.

Chairman:—The business before you now is the consideration of that part of the Committee's report dealing with the election of officers and committees.

Dr. Halsey:—I move you that the Secretary be instructed to cast a ballot for the officers and committees nominated. Seconded.

The Secretary cast the ballot and announced that the officers and committees as nominated by the Nominating Committee had been elected.

Dr. English:—There were two recommendations and one was that the President have the power to appoint delegates to certain societies. Seconded.

Chairman:—It has been moved and seconded that that part of the report be adopted. Carried.

Dr. Chandler:—Unintentionally we have omitted the election of the delegates to other State societies. I move that this take the same course as the election of officers. Seconded. Carried.

Dr. Chandler:—The ballot is cast and I announce the election of these delegates.

Dr. D. C. English:—Now as to the time and place of meeting, I would merely state, as Chairman of the Nominating Committee, that an unusual amount of time was given to the discussion of this question. It took several votes before we could decide to make any recommendations.

With regard to holding it at the same time as the national association all the gentlemen were convinced that, if held at the same place and in the same week the meeting would be a failure. The Medical Society of New Jersey, the oldest medical society in the country, it is believed, should attend to its own business and in a dignified manner. The American Medical Association meets in all probability during the last of May. It is the opinion of the Nominating Committee that if our State Society should meet one month later we would have an attendance fully as large as we are in the habit of having. There were other propositions, such as holding our meeting during the middle of next September, but we believe that would not be feasible. The majority of the physicians will have had their vacations then and they will not feel like

leaving their work again so soon thereafter. So this was voted down by a unanimous vote. After a careful consideration of the pros and cons it was decided that the last week in June would be the most suitable time for us to hold our meeting with credit to ourselves and to our time-honored society.

Dr. Benjamin:—I move the adoption of the remainder of the report as presented by the Nominating Committee. Seconded.

Dr. Chambers:—I feel a little uncertain. If the American Medical Association is to meet at the same time with our society it will detract from the interest in our work. Therefore, I feel like making an amendment, that our Society shall meet two days only instead of three. I think it wise to have two days and not three. As a member of the Committee on Scientific Work I wish to state that I do not like to ask people to read papers to empty seats. I, therefore, make the amendment that we meet for two days instead of three. Seconded.

Dr. Chandler:—I doubt if we shall be able to complete our business in two days. We practically have two solid days now. Most of you came here yesterday and go away to-morrow. While our meeting covers portions of three days it is actually but two days. If this amendment is to be adopted I hardly see how we can accomplish the work. I, therefore, doubt the propriety of changing the length of our annual session.

Chairman:—I hope to make the next meeting the best we ever had and I would dislike to curtail the time.

Dr. English:—Allow me to remind the Society that the question of time and place can be arranged by the Board of Trustees. If a satisfactory reason for changing the time and place is presented, they have the power to make the change. If anything develops between now and the next meeting, the Board of Trustees may be called together to consider it.

Amendment lost. Original motion carried.

APPOINTMENT OF COMMITTEES.

Chairman:—I will now appoint the following committees:

Honorary Membership—H. GENET TAYLOR, *Chairman*, Camden; E. J. MARSH, Paterson; L. M. HALSEY, Williamstown.

Credentials—DANIEL STROCK, *Chairman*, Camden; ARCHIBALD MERCER, Newark; THEODORE SENSEMAN, Atlantic City.

Committee on Business—J. P. HECHT, *Chairman*, Somerville; W. E. HALL, Burlington; P. A. HARRIS, Paterson; JOS. HUNTER, Jr., Westville; EMERY MARVEL, Atlantic City.

REPORT OF THE COMMITTEE ON HYGIENE
AND LEGISLATION.

This report was presented by Dr. L. M. Halsey, chairman of the committee, as follows:

The Medical Society of New Jersey:

Your Committee on Legislation, in making their report, feels that it will be proper to present to you a resume of the work during the past year.

In October, 1905, Dr. Charles Young, Chairman of the Committee, resigned, and Dr. Alexander Marcy, Jr., acting President of the Society, appointed Luther M. Halsey to fill the vacancy.

Following the resolution of the State Society in the appointment of an Auxiliary Legislative Committee, to consist of one member from each County Medical Society, this committee was appointed by the retiring President, Dr. Walter B. Johnson. The Chairman of the Legislative Committee felt that in many instances there might be less friction and more hearty co-operation in the work if appointments to this committee were made by several County Societies. A letter was sent to the County Societies notifying them of the appointees of the President, and suggesting that if the one selected to represent their County Society on this committee was not satisfactory, or who would not be willing to devote time and active work along this line, the County Society should suggest a name to the chairman of the committee, who would be appointed. In several instances this was done, not with any spirit of antagonism, but with the sole idea that it would work to the very best advantage in legislative matters.

Early in November, after the receipt of a communication from Dr. Charles L. Reed, chairman of the National Legislative Committee of the American Medical Association, a notice was sent to the several district societies in the State asking them to notify the chairman of the appointment of a member on the committee, to be known as a National Auxiliary Legislative Committee. Most of the societies complied with this request, but it became necessary in several instances for the chairman to make appointments. We are satisfied that the appointment of the National and State Auxiliary Legislative Committee has been of marked assistance to us from the fact that more men are vitally interested in the work.

The County Medical Societies were notified of our proposed plan of campaign, and asked if it were possible to get pledges from the prospective members of the Legislature in opposition to any Osteopathic measure which might be introduced. The reports from the societies claimed that it was too late at that time to get the necessary pledges.

At the meeting of the committee early in December a notice was sent out to the individual members of the Legislative Committee asking their hearty support in opposition to Osteopathic legislation. Slips were prepared which were distributed freely to the County Societies throughout the State asking that they be signed by the members of their Society and by prominent laymen in opposition to a bill to license Osteopaths. This did not meet with the hearty approval of the profession that we had hoped, as 8,000 slips were distributed throughout the State and only about 1,400 were returned.

At a meeting of the Legislative Committee early

in February it was decided to send a return postal card to every physician in the State asking for his signature in opposition to the Osteopathic bill when introduced into the Legislature. As the hearing on this measure was fixed on such an early date after the meeting of the Legislative Committee this plan was abandoned. We had no official notification of the hearing granted on this bill, but hurriedly sent out notices to the members of the different societies calling their attention to the date of the hearing and asking them that a full representation be present in opposition to this measure.

While the osteopaths had able legal talent to represent them, we feel that our side was very ably presented. Owing to the short time allowed for the discussion, we asked the Public Health Committee of the Assembly to grant us an additional hearing on this bill for the purpose of further presenting our objections to it. This was granted, and at the hearing we had a strong delegation present to oppose the passage of this measure. We are very glad to be able to state that this bill was never reported by the committee.

The committee at this time desires to express their appreciation of the work of Dr. Edward E. Haines, a member of the Public Health Committee of the Assembly. Dr. Haines nobly upheld the honor of the medical profession, standing at all times as a stone wall against the reporting of this measure, and to him and the other members of the committee who resisted the enormous pressure that was brought to bear upon them, known only to those who were closely associated with the work, should be given the hearty thanks of this Society for their untiring devotion to the medical profession and the safeguarding of the interests of the public at large.

A measure was introduced into the Legislature known as the Nostrum or Patent Medicine Bill, received the hearty support of the committee, and we did everything in our power for its passage, but without avail.

At the hearing on this bill Mr. Bok, of the *Ladies' Home Journal*; Rev. Dr. Handley, of Long Branch, and Dr. B. D. Evans, spoke strongly in favor of it. We felt that this measure would be favorably reported to the Senate as the Legislative Committee had the promise that it would be done, but tremendous pressure was brought to bear upon the members of the Legislature by the patent medicine men and the Pharmaceutical Association of New Jersey, and it was not reported to the Senate.

At the meeting of the Legislative Committee in February, by special invitation to the president of the New Jersey Pharmaceutical Association, Mr. William A. Davis, and the chairman of their Legislative Committee and Mr. Henry A. Jordan were present. The question as to the support of the committee in regard to this Patent Medicine Bill was gone over very carefully. Mr. Davis and Mr. Jordan stated that if some things in the bill were eliminated they would be ready to thoroughly support it.

A committee was appointed to confer with the introducers of the measure, with the understanding that these parts should be taken up and thoroughly discussed, and the two measures which had been introduced in the Senate should be made identical, or a substitute introduced for the two, which we then supposed would have the endorsement of all parties interested. To our surprise the Pharmaceutical Association worked untiringly against the measure and at a recent meeting of

their association they claimed that it was due to their energetic efforts that the passing of any acts which would lessen or limit the sale of proprietary medicines was stayed; and they further state that any legislation of this character should emanate from them, and that they were not willing that any measure should become a law unless it met with their entire approval. We feel sure that if the same hearty, energetic work is done for this measure as was done in opposition to the Osteopathic Bill, that we will see placed upon the statute books of the State of New Jersey a law regulating the sale of nostrums.

We wish to take this opportunity to thank the Homeopathic State Medical Society for their hearty coöperation with us in all legislative matters.

The entire expenses of the Committee on Legislation up to the present time has been paid by the chairman of the committee. We feel that you should take such steps as will put aside a certain amount that the committee can draw upon from time to time as the necessities may require.

We would suggest that the committee be empowered to procure a directory, to be the property of the Committee on Legislation, as frequently during the last season this would have been of inestimable value to us.

We further suggest that the committee be empowered to consult and employ counsel in case of need to draft bills, scrutinize legislation, conduct hearings, and to advise the committee on the proper course that they should pursue in all legislative matters.

Owing to the resignation of Dr. Young there is a vacancy in the committee at present, and we would suggest the name of Dr. H. H. Davis, of Camden, to fill the vacancy. Dr. Davis was untiring in his work, being present at every meeting of the Legislative Committee and acted as its secretary. It is a just recognition of his services to the committee and to the Medical Society of New Jersey.

If we are to accomplish much in the future in the matter of controlling or regulating legislation which is of vital interest to the medical profession of the State and humanity at large, there must be a thorough and systematic organization, and while most of our county societies responded promptly to our requests for reports and investigations, yet there is a lamentable failure in many instances.

For your committee to accomplish much they must have prompt and explicit reports. Let us all determine that we will have in the coming year more full and systematic organization than in the past. While we are satisfied that the medical men of New Jersey are better organized today than ever before and are more widely awake to the necessity of taking decided action in legislative matters, yet there is marked room for improvement.

We would suggest that the county medical societies see that good men are placed upon the National and State Auxiliary Legislative Committees; men who are in sympathy and who are willing to do thorough and conscientious work.

To those county societies who have labored earnestly for every suggestion that has been thrown out by the committee, we wish to return our hearty thanks. We would like to place upon the role of honor all county societies who have done good work during the past campaign—the counties of Somerset, Hudson, Burlington, Cam-

den, Gloucester, Atlantic, Morris and Ocean, these are deserving of special mention, for the reason that they have assisted your Legislative Committee in every matter that they were called upon to do.

The committee desires to personally thank those who so ably spoke at the different hearings granted by the Legislature. They responded nobly to the requests of the chairman of the committee and were untiring in their exertions to assist the committee in every way possible.

To the Auxiliary Legislative Committees as a whole we wish to express our thanks for the valuable assistance they have given us.

Let us all promise ourselves in the future that we will put our shoulders to the wheel; have a more systematic and thorough organization; watch closely all legislation, and give notice to the general public that we as physicians are men who should shape legislation which is of vital interest to the health of the community at large.

Let us undertake a campaign of education; and when this is well done we are satisfied that the lawmakers and the public at large will be only too ready to refer all questions of sanitation, and all matters which will affect the public health of the State, to its physicians who have so nobly shown in the past that their first aim in life is to do everything in their power to relieve human suffering; to prevent epidemics, and to control diseased conditions with a firm hand. When this is accomplished the work of your Legislation Committee will be comparatively easy, from the fact there then may be no need of such a committee in the sense in which the present body is constituted.

The chairman of the committee desires to personally thank all those who have so nobly assisted him in the work which he has tried to carry out, and to say that he thoroughly appreciates the many kind letters which he has received from medical men throughout the State speaking favorably of what has been accomplished.

Dr. Kipp:—On behalf of the Society I move that the report be received and that we approve the recommendations in so far as they involve the expenditure of moneys.

Chairman:—What will you do?

Dr. McLaughlin:—I move you that the report be received and with thanks. Furthermore, inasmuch as Mr. Haines has served this Society so faithfully and ably he ought to receive the thanks of this Society and in the form of a personal letter.

Chairman:—The recommendation is regarding the furnishing of funds; the Treasurer should be advised to advance such sums as the Legislative Committee asks for. Carried.

Dr. Halsey:—The committee proposed to have suitable resolutions engrossed and presented to Dr. Haines as an expression of favor from the Society. I think this was approved of by the Board of Trustees.

Dr. Kipp:—The Trustees approved of that. I move you now that we extend thanks to the committee for the work they have accomplished.

Dr. English:—I take great pleasure in seconding that motion. I do not believe that most of the members of this Society realize the amount of work this committee has done for the Society. Dr. Halsey especially has done an immense amount of work and has done it cheerfully and without compensation. I second that motion most heartily.

Chairman:—Are you ready for the question? All in favor of the motion please stand. Carried.

Dr. Halsey:—We appreciate your vote of confidence. We have tried to do our duty. If all try to assist the committee and give full and explicit reports, doing all in their power to assist in the campaign of education we propose for the coming year, then the medical men of New Jersey will come out victorious.

Dr. Schauffler:—I move that Dr. J. C. Wilson, of Philadelphia; Dr. H. A. Hare, of Philadelphia, and Dr. LaPlace, of Philadelphia, be invited to sit with us and take part in our discussions. Seconded.

Dr. English:—I amend that motion by including all medical men who are here and are not members of the Society. Seconded. Motion and amendment carried.

REPORT OF COMMITTEE ON BUSINESS.

Dr. Hecht:—The committee recommends that the question of a contribution to the memorial to Dr. N. S. Davis, of Chicago, asked for in Dr. Henry O. Marcy's letter, be referred to the Board of Trustees.

In reference to the motion of Dr. Schauffler that the Medical Society of the State of New Jersey assume the defense of its members, it is suggested that a committee be appointed to consider the matter and report at the next annual meeting.

Dr. Chandler:—By request I again will read Dr. Marcy's letter. (Read.)

Chairman:—This was read yesterday and it is now recommended that it be referred to the Board of Trustees.

Dr. Wilson:—I move that the recommendation of the Business Committee as to Dr. Marcy's letter be adopted. Seconded. Carried.

Dr. Hecht:—In reference to Dr. Schauffler's motion regarding the medical defense of the members of this Society, am I to understand that this is to be referred to a committee for examination and consideration, and that it will report at the next annual meeting?

Chairman:—It has been moved and seconded that the resolution of Dr. Schauffler presented yesterday, "that the Medical So-

ciety of New Jersey assume the defense of its members in case of malpractice suits" be referred to a special committee of three, to be appointed by the chair, and who will report upon this at the next annual meeting. What is your pleasure? Carried.

Business Committee recommends that Dr. Baldwin's resolution be changed to read:

"That the Medical Society of New Jersey shall make nominations to the Governor of the State when a vacancy occurs that lessens its usual quota on State Board of Examiners."

J. P. HECHT,
P. A. HARRIS,
B. A. WADDINGTON.

Dr. Godfrey:—Personally I have no objection to such a procedure, but you cannot accomplish that in a legal way. No one has the right to dictate to the Governor whom he shall appoint. Neither can he listen to you because all appointments are referred to the Senate. The Governor may *recommend*, but he has no jurisdiction beyond that.

Chairman:—I think that is the purport of the resolution. This Society has no authority to do otherwise than recommend.

Dr. Rector:—I do not quite understand how you expect to influence the Governor in asking for the promotion or appointment of such and such a man. We are giving away our rights and prerogatives and stepping beyond our power. We may become legislators.

Dr. Baldwin:—The resolution offered is for the purpose of taking the State Board of Medical Examiners out of politics. We do not assume that it is a political board; at the same time it will give a better color and will meet the approbation of medical men, according to my idea, to present such a resolution. The Governor still has the power to appoint and we have no right to take that power away from him. At the same time we can express our choice regarding the member of the State Board. When it was first organized there was a bitter feeling from various causes; among those causes was the one that it might be more or less a political board. The resolution as proposed is simply a respectful recommendation to the Governor of the State to consider the names of such medical men as shall be given him by this Society, no other body being more adapted to give them than this Society. I have reason to believe that the Homeopathic Medical Society of this State will follow this course. I know that recommendations made by the State Dental Board and State Pharmaceutical Board were similar to those in this resolution. I cannot see how any disrespect is

shown the Governor. We want, however, to assert ourselves.

Dr. Davis:—If I am not mistaken, the Pharmaceutical Board of this State also made such a resolution. Coming from this Society it might meet with approval. The present Governor would regard this approval of medical men. Certainly no harm can come from the adoption of such a recommendation.

Dr. Benjamin:—Our Society has sometimes been on the wrong side. For instance, when it was proposed to have a State Board of Health we voted that we would have no board, rather than a mixed board. I say it stands to-day on record. I worked for fifteen years to get—

Chairman:—Speak to the resolution. Shall we or shall we not pass the resolution recommending to the Governor of the State candidates for appointment on the Board of Medical Examiners?

Dr. Benjamin:—In a minute. For fifteen years I say I tried to get a Medical Examining Board. A committee was appointed which made a report in 1889 with diverse (adverse) recommendations. I was the only one who opposed that report. The report was adopted and the Society stands to-day on record as opposed to such a State Medical Examining Board. I am sorry that this mistake was made. However, we went to Trenton and got the bill through in 1900. It passed. Because of the expressed opinion of Mr. Sewell regarding political pulls, etc., we not get his support; when we did go he would stand aloof. But if we are going to stand aloof and allow influential politicians to make the recommendations, then it places the Board in a position to dictate and coerce, etc., and so at least they could coerce the members of the Society. Now, why should not the medical men of the State be allowed to suggest what they want? The Governor would consider it an assistance to have it so. The action of the State Society will go back to the County Societies and then it will go back to the Senators, and sentiment in this matter can be controlled. They can say that the recommendations are merely a protection against incompetent men and unwise legislation. They can go to the Governor and we can go to the voters. I hope the resolution will be passed.

Chairman:—The resolution has been offered and seconded; what is your wish? Carried.

Dr. Curtis:—I move that the Committee on Program be instructed to print on the

program the day and the hour the Nominating Committee will hold its session. Seconded. (Carried.)

On motion the House of Delegates was declared adjourned and the Society opened in general session.

The following papers *were read and discussed:

"The Surgical Treatment of Gastropno-sis," Henry D. Beyea, Philadelphia. Discussion opened by Gordon K. Dickinson, Jersey City, and continued by Drs. Noble, Gray and Balleray.

Dr. Emery Marvel:—I move that Dr. W. L. Rodman be made a corresponding member of our Society and be invited to take part in the discussion. Seconded. (Carried.)

Chairman:—It is also moved that Dr. Montgomery be invited to sit with us and take part in the discussions. This has been seconded. (Carried.)

"The Omentum and Its Functions."—G. K. Dickinson, Jersey City.

SYMPOSIUM ON APPENDICITIS.

"Etiology of Appendicitis."—T. H. Mackenzie, Trenton.

"Diagnosis of Appendicitis."—Ellis W. Hedges, Plainfield.

"Complications and Sequels of Appendicitis."—Paul M. Mecray, Camden.

"Treatment of Appendicitis."—F. D. Gray, Jersey City.

On Wednesday evening the Committee of Arrangements provided an entertainment for the Society in the Hotel Chelsea.

THIRD DAY—THURSDAY JUNE 21.

GENERAL SESSION, 9 A. M.

"Neurasthenia and Hysteria."—M. J. Synnott, Montclair. Discussion opened by G. H. Balleray, Paterson, and J. C. McCoy, Paterson.

"The Treatment of Chronic Nervous Conditions."—W. G. Schaffler, Lakewood. Discussion opened by I. H. Hance, Lakewood.

These papers were discussed by Drs. Leszynsky, Silvers, Walling, Chambers, Sutphen and Johnson.

"Chorea and Its Management."—Thomas P. Prout, Summit. Discussion by Drs. R. C. Newton, Balleray, Johnson, Coit and Margaret P. Brewster.

"A Plea for the Use of the U. S. Pharmacopoeia vs. Proprietary Preparations."—

* These papers and discussions will appear in the JOURNAL.

H. H. Sherk, Camden. Discussion by Drs. Strock and F. M. Corwin.

Chairman.—I cannot conscientiously close this session without asking you to pass a vote of thanks to the Committee on Scientific Work for the able programme presented, for the character and the arrangement of the papers, and the expeditious manner in which they were presented. I think this committee is entitled to our thanks.

Dr. Johnson.—I so move. Seconded.

Dr. English.—The programme has been carried out entirely. Each one has responded. Every paper on the programme has been read.

Dr. Taylor.—This is the most successful meeting we have ever had. The papers offered to us were scientific and were listened to with unusual interest.

Carried.

On motion, the General Session was adjourned *sine die*.

The House of Delegates was then called to order.

Chairman.—The Chair wishes to make a few announcements. First of all, I shall read the names of the special committee on medical defense:

MEDICAL DEFENSE.

Special Committee on "Medical Defense"—W. G. SCHAUFFLER, *Chairman*, Lakewood; T. N. GRAY, Orange; W. P. MELCHER, Mt. Holly.

Chairman.—I have been asked to place Dr. Randolph Marshall on the Committee of Arrangements, and I add his name to that committee.

Chairman.—The Chairman of the Committee on Registration informs me that there registered 208 delegates. Last year we had 196.

Dr. Chandler.—I should like to call attention to the resolutions contained in Dr. Wilson's paper. Action on them was deferred. By request Dr. Wilson read the resolutions, as follows:

WHEREAS, The value of perfect sight and hearing is not fully appreciated by educators, and neglect of the delicate organs of vision and hearing often leads to disease of these structures; therefore be it

Resolved, That it is the sense of the Medical Society of New Jersey that measures be taken by boards of health, boards of education, and school authorities, looking to the examination of the eyes and ears of all school children, that disease in its incipency may be discovered and corrected; and be it further

Resolved, That this Society instructs its Legislative Committee to endeavor to secure the passage of a suitable bill relating to this matter at the next session of the legislature.

Dr. Chambers.—I move their adoption. Seconded. Carried.

Dr. Synnott.—I have prepared a set of resolutions having to do with regulating life insurance examination fees. Most of the insurance companies sent out circular letters announcing that the fees had been cut down. Many societies have already placed themselves on record as opposed to such an arbitrary reduction of fees. It seems an insult to the profession that we allow ourselves to be placed in such a position that we can be attacked so arbitrarily by these insurance companies. We all know that the work required of us requires skill and judgment. We all know that the examination as required now by the insurance companies demands a much larger fee than that offered under the new schedule. Personally, while I do not do as much life insurance work as others, still I have a very strong feeling in the matter and have taken a positive stand myself without waiting for the action of this Society. I have written to four insurance companies, the Penn Mutual, the Colonial, the Manhattan and the Equitable, for which I have examined, telling them that I would not abide by the reduced scale of fees, and that I would not consider any fee less than five dollars (\$5.00). In each case I have received a courteous reply and asking for reasons. I think we should stand together; by so doing we can compel the companies to respect our rights and get a respectable fee for our work. The companies want good men. If we do not stand together our resigning will have but little effect because our positions will be quickly filled by others. But if the Society takes a decided action and makes a strong plea for a five dollar (\$5.00) fee as the minimum fee for life insurance work, the life insurance companies will come to our terms and recede from the arbitrary position that they have taken.

I wish to offer a resolution that this Society places itself on record as opposed to such a reduction of fees for medical examination work for life insurance companies, and that five dollars (\$5.00) be the minimum fee.

Dr. Schauffler.—I wish to second that motion. The three companies that I examine for, the New York, the Mutual and the Phoenix, have made a similar reduction in fees recently. I cannot examine at the reduced rate. There are one or two in the city doing the work so that my action alone has not much effect. If the profession would

stand together as opposed to such a reduction it might carry some weight.

Dr. Fisher:—I am glad this matter has come up. A few years ago the New York Life Insurance Company cut down the fees for examination to three dollars and less and I resigned. The Equitable did the same thing and I promptly resigned. Eighteen months after they sent me a notice asking me to reconsider my action and raised the fee to five dollars. Some time during last February the New York Life, the Mutual Life and the Equitable Life told me of the great necessity for economy, and therefore they had cut down the fees, that when the insurance was for \$3,000 and under the fee would be three dollars. I answered those companies that my fee would be five dollars, and that I could see no reason for such a reduction. I presume that I was dropped from the rolls.

In regard to the Penn Mutual they offer three dollars for an examination where the insurance was one thousand, but there is no urinary examination on their blanks. I wrote them that I should be glad to consider that. I think this matter should come before the next meeting of the State Society, and while I am inclined to accept smaller fees yet I shall consider myself bound by the action of this Society.

Dr. Walter B. Johnson:—I wish to offer an amendment, "that a copy of the resolution be sent to the officers of the insurance companies." Seconded.

Dr. D. C. English:—The amendment is good. I believe that the men who are responsible for the action of the insurance companies are Medical Directors. Some time ago open letters were sent out by the companies concerning the reduction of fees. On applying to the company I was told that this matter was in the hands of the medical department. I sent a communication to the Medical Directors, and they referred me back to the company. Such conduct is unworthy of gentlemen who are serving as Medical Directors and are drawing large salaries for their services. It is strange they do not appreciate the value of the services rendered by their medical examiners. I am heartily in favor of this resolution and also the amendment offered by Dr. Johnson. The members of this Society should take a united stand.

Dr. Johnson:—The companies should be informed that the Society places itself on record that five dollars is the minimum fee to be charged.

Dr. Newton:—It seems to me that this

would have no effect unless you attach a penalty for violation by members of this Society.

Chairman:—A man's conscience should be considered.

Dr. English:—We should stand firm on this point.

Dr. Parsons:—I had a letter from the New York Life telling me of the necessary economy and asking the favor of a postal card in reply to whether I would accept a three dollar fee.

Dr. Newton:—The law requires the reduction of fees.

Dr. Synnott:—That law is only in force in New York State. It undoubtedly will be declared unconstitutional.

Chairman:—As various views have been expressed, I will appoint a committee to draw up a resolution embodying these views. I will appoint Dr. Synnott and Dr. Chandler. Dr. Synnott presented the following resolution:

Resolved, That it is the sense of this Society that hereafter in each life insurance examination the minimum fee shall be \$5.00, and that a copy of this resolution be sent by the Secretary to our component Societies, to each State Society, and to the different life insurance companies of this country.

Chairman:—The resolution and amendment have been seconded. Carried.

Dr. Newton:—I offer the following resolution:

WHEREAS, It has been stated in the public prints that the entire medical and surgical staff of St. Joseph's Hospital, in Paterson, have resigned from that institution rather than acquiesce in certain movements calculated to impair the efficiency of the service; and

WHEREAS, It appears that certain other physicians in Paterson, instead of sustaining their colleagues in the stand they have taken, have accepted the positions made vacant by their resignations; therefore, be it

Resolved, That this Society censures the action of those physicians who accepted the positions thus made vacant.

Dr. D. E. English:—I will second that if you will leave out the first portion of the resolution.

Dr. Newton:—I merely want action taken on this.

Dr. Kelly:—I fear that this matter is not properly understood. There is a relation there between the staff resigning and the new staff appointed. I think the State Society should make inquiries regarding this before they take further action. It should know the true status of affairs. I see no reason why the State Society should take action in a matter of this kind.

Dr. D. C. English:—I am decidedly of the opinion that we should act intelligently and justly, and we cannot do so without having the facts in the case. Let us go slow in passing censure. I move that this matter be referred to the Judicial Council.

Dr. Newton:—I shall be glad to shape the resolution according as Dr. English desires. I want the matter investigated. I have no personal feeling, but I should like to have it investigated and reported on.

Dr. Walling:—This is mere rumor and there is no evidence given to make us take action.

Chairman:—It has been moved and seconded that this matter be referred to the Judicial Council.

Dr. Gray:—I move the motion be laid on the table. Seconded. Motion lost.

Chairman:—The other motion is before you; what is your pleasure? Carried.

Chairman:—Some one should offer a resolution thanking the Committee of Arrangements for their arduous work, energetic efforts, etc., towards making such a successful meeting as has been held this year. To the Chairman, probably more than to any other, do we owe the greatest amount of gratitude. This gavel is from the Chairman of the Committee of Arrangements of the Medical Society of the State of New Jersey at its 140th annual meeting, and is to be relegated to antiquity. There are bull dog teeth on the handle. I want to thank the gentlemen for the very kindly manner in which they have seconded my efforts in presiding over this meeting.

Dr. D. E. English:—I will be glad to make such a recommendation and also include the gavel, which should be formally presented by the Chairman of the Committee on Arrangements. Seconded. Carried.

Dr. Chambers:—I understand this hotel has offered us its minimum rate of three dollars. I move a vote of thanks to the hotel establishment. Seconded.

Dr. Marvel:—The hotel has contributed a great deal to our pleasure and comfort and the proprietor has made a reduction for the Society. I hope you will take proper cognizance of this. Carried.

Dr. Kipp:—The action taken yesterday afternoon regarding the Board of Medical Examiners was incomplete. I have been requested to offer the following resolution:

Inasmuch as the resolution passed by this Society concerning recommendations to the Governor of "appointees for the State Board of Medical Examiners" contained no provisions for carrying out the wishes of the Society, therefore be it

Resolved, That the Board of Trustees of the Medical Society of New Jersey shall have power and it shall be their duty to offer ten names, more or less, in their discretion, for consideration by His Excellency; any one or more of whom would in their judgment be acceptable to this Society.

Dr. Kipp:—Dr. Benjamin wishes to add to it:

Provided, That no member of the Board of Trustees, except such as are now holding appointments on medical boards selected by the Governor, shall be eligible or recommended for appointment.

I do this to remove any possible suspicion that the Trustees are interested as candidates.

Dr. Johnson:—I wish to offer an amendment to the amendment, and that is that this resolution shall include the officers and nominations for every position to be filled by medical men in the State of New Jersey, either in asylums, prisons, or other medical positions besides the Board of Medical Examiners.

Dr. Taylor:—I second Dr. Kipp's amendment.

Dr. English:—I second Dr. Johnson's amendment to the amendment.

Dr. Newton:—I think the members of this Society will agree with me that we are entering upon a new field and this requires thought. I think that Dr. Johnson's amendment is a good one. But I think this whole matter should be referred to the Judicial Council for further study. More time should be taken to think about this.

Dr. Johnson:—I withdraw my amendment.

Chairman:—Dr. Kipp's amendment is before you. Carried.

Chairman:—Dr. Benjamin's addition to the resolution is before you. Carried.

Chairman:—We will now vote upon the original resolution of Dr. Benjamin.

Dr. Newton:—I make an amendment that the whole matter be referred to the Judicial Council.

Chairman:—You are out of order. We will now vote upon the resolution itself.

Carried.

Dr. Godfrey:—I want to say that the State Board of Medical Examiners extend an invitation to you to meet in Trenton next October and go thoroughly over this subject. As Secretary of the State Board of Medical Examiners I extend that invitation to visit us at Trenton. This Society should take an interest in every organization and every institution of the State under medical direction. It would help the Society ma-

terially; we should focalize all medical interest in the State in the Society. I now wish to introduce this resolution:

Resolved, That this Society recommend to the Governor two physicians, one of whom may be selected, if desirable, for appointment to any vacancy formerly held by a physician, that exists or may exist in the State Board of Health, the Tuberculosis Commission, the Board of Trustees or Directors of the Village of Epileptics and of the State Hospitals at Trenton and Morristown;

Resolved, That the Board of Trustees of this Society be directed to carry out these recommendations through the Secretary of this Society.

Dr. Johnson:—I second that motion. Carried.

Dr. Wilson:—As an amendment to Dr. Godfrey's resolution I would include the State prisons and reformatories.

Dr. Johnson:—This was included.

Dr. Wilson:—I withdraw the proposed amendment.

Dr. Marvel:—Dr. Chew has taken care of the exhibitors and of exhibition spaces and has been of invaluable aid to us. We all are more than gratified at the results of this meeting.

Dr. Johnson:—I move that the Secretary write a letter thanking the Committee of Arrangements for the valuable work they have done. Seconded. Carried.

On motion, the House of Delegates adjourned.

WM. J. CHANDLER, Secretary.

AN ALPHABETICAL LIST

Of the Members of the Medical Society of New Jersey.

Compiled July, 1906.

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Alsop, Thomas.

Allis, Jeremiah A., Park St., Upper Montclair.
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Andress, Theophilus H., Sparta, Sussex Co.
Applegate, Asher T., Englishtown, Monmouth Co.
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Areson, William H., Upper Montclair, Essex Co.
Arlitz, William J., 630 Bloomfield, Hoboken.
Armstrong, Alex., 323 So. Broad, Trenton.
Armstrong, Ed. C., 512 Fulton, Town of Union, Hudson Co.
Armstrong, Samuel E., Rutherford, Bergen Co.
Ashcraft, Samuel F., Mullica Hill, Gloucester Co.
Asher, Maurice, 20 Court, Newark.
Asnis, E. J., Woodbine, Cape May Co.
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Baker, E. Mills, 103 Wayne, Jersey City.
Baker, George H., Long Branch.
Baker, R. D., Summit, Morris Co.
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Baldwin, Samuel H., 473 Clinton av., Newark.
Baldwin, Winfred E., 462 Orange, Newark.
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Barber, Isaac, Phillipsburg, Warren Co.
Barnes, William M., Springfield, Union Co.
Barrington, R. C., Mt. Holly, Burlington Co.
Barrows, Arthur M., 300 S. Clinton, Trenton.
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Bartow, Geo. W., Three Bridges, Hunterdon Co.
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Bateman, Frank M., Cedarville, Cumberland Co.
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Beatty, Henry M., 50 Centre, Trenton.
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Beekman, John B., Pluckamin, Somerset Co.
Beling, C. C., Morris Plains, Morris Co.
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Best, George N., Rosemont, Hunterdon Co.
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Bilderback, Francis, Salem, Salem Co.
Bingham, Arthur W., 209 Main, East Orange.
Bisset, John J., South River, Middlesex Co.
Blackwell, Enoch, Clinton, Hunterdon Co.
Blair, J. E., Burlington.
Blake, Duncan W., Gloucester, Camden Co.

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 Bleick, Theodore E., 340 Waverly av., Newark.
 Bleick, William D., 577 Clinton av., Newark.
 Blenckstone, Fred O., Oradell, Bergen Co.
 Bleyle, Herman C., 15 Walnut, Newark.
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 Blundell, William, 236 Main, Paterson.
 Bogardus, Henry J., 427 Bergen av., Jersey City.
 Boone, William C., Seventh, Plainfield.
 Borgmeyer, J. G. Lewis, 90 W. 8th, Bayonne.
 Bossard, H. B., Harmony, Warren Co.
 Bossert, L. H., Newport, Cumberland Co.
 Bowden, David T., 117 Paterson, Paterson.
 Bowyer, Frank F., 262 Barrow, Jersey City.
 Boyer, C. H., Riegelsville, Warren Co.
 Boyle, Thomas P., 110 Bellville av., Newark.
 Boysen, Theophilus H., Egg Harbor, Atlantic Co.
 Bradford, E. B., Port Norris, Cumberland Co.
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 Brewster, Guy Otis, Grantwood, Bergen Co.
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 Brouwer, Frank, Toms River, Ocean Co.
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 Burt, F. C., Hammonton, Atlantic Co.
 Burt, N. Howard, Ocean City, Cumberland Co.
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 Campbell, W. R., Long Branch.
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 Carman, John H., 518 Watchung av., Plainfield.
 Carpenter, A. Eldridge, Boonton, Morris Co.
 Carpenter, William H., Salem, Salem Co.
 Carpenter, Wm. R., Mt. Pleasant, Hunterdon Co.
 Carrigan, Eugene E. S., Pt. Pleasant, Ocean Co.
 Carroll, Alexander J., Morris Plains.
 Carroll, Edgar, Main, Dayton, Middlesex Co.
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 Cole, Martin, Hainesville, Sussex Co.
 Coleman, Joseph G., Hamburg, Sussex Co.
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 Condict, Isaiah W., Dover, Morris Co.
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 Conover, J. H. P., 1143 E. Jersey, Elizabeth.
 Conrad, Edgar K., Hackensack, Bergen Co.
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 Cook, Mary, 91 Mt. Prospect av., Newark.
 Cook, Richard L., Dover, Morris Co.
 Cooke, Henry G., 7 Livingston av., New Brunswick.
 Cooper, E. P., Parsippany, Morris Co.
 Cornwell, Alfred, Bridgeton, Cumberland Co.
 Corson, E. S., Bridgeton, Cumberland Co.
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 Corwin, Theodore W., 5 W. Park, Newark.
 Cory, Horace C., 224 Broad, Newark.
 Cossitt, Harry A., Morris Plains, Morris Co.
 Costill, Henry B., 506 E. State, Trenton.
 Coultas, Aldo B., Madison, Morris Co.
 Courtwright, Everett P., 17 Centre, Newark.
 Craig, Burdette P., Blvd. and Highld. av., J. City.
 Cramer, Alfred, 433 Penn., Camden.
 Cramer, Isaac S., Flemington, Hunterdon Co.
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 Crawford, David H., 14 Bridge, Newark.
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 Cregar, Peter B., 406 Grant av., Plainfield.
 Creveling, William S., Valley, Hunterdon Co.
 Crittenden, Thomas R., Dover, Morris Co.
 Cropper, Charles W., 85 Gifford av., Jer. City.
 Cross, Anna M., 20 Marshall St., Newark.
 Crounse, David R., 84 Bloomfield av., Passaic.
 Culver, D. Le Roy, 287 York, Jersey City.
 Culver, George M., 49 Tonnelle av., Jersey City.
 Culver, S. Herbert, 98 Magnolia av., Jersey City.
 Cummins, eGorge W., Belvidere, Warren Co.

- Cunningham, Jos. A., 591 Warren, Newark.
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 Curtis, Frank W., Stewartsville, Warren Co.
 Curtis, Robert M., 30 Church, Paterson.
 Curtis, James H., 30 Church, Paterson.
 Cuskaden, Albert D., 2 S. Mich., Atlantic City.
 Dallas, Alexander, 24 E. 22d, Bayonne.
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 Davenport, George S., Garfield, Passaic Co.
 Davenport, Peter P., Vailsburg, Essex Co.
 Davidson, Louis L., 173 Spruce, Newark.
 Davis, Henry H., 569 Benson, Camden.
 Davis, Henry V., North Branch, Somerset Co.
 Davis, John B., 6th and Lawrence, Camden.
 Davis, Richard, M., Salem, Salem Co.
 Davis, William A., 511 Cooper, Camden.
 Davis, W. H. K., 42 N. Arlington av., E. Orange.
 Davis, W. Price, 1721 Pacific av., Atlantic City.
 Davison, C. K., Stanhope, Sussex Co.
 Day, Grafton E., Camden.
 Day, Harry V., Butler, Morris Co.
 Day, S. Thomas, Port Norris, Cumberland Co.
 Dearborn, R. B., 1028 E. Jersey, Elizabeth.
 Decker, Clinton L., Boonton, Morris Co.
 Decker, Fred W., Frenchtown, Hunterdon Co.
 Dedrick, Thomas S., Washington, Warren Co.
 De Groft, Eugene E., Woodstown, Salem Co.
 De Groot, George S., Mendham, Morris Co.
 De Hart, Clara M., 99 Mercer, Jersey City.
 De Jager, Simon, 83 Bridge, Paterson.
 Demarest, Fred F. C., 29 Academy, Passaic.
 De Merritt, Charles L., 302 Shippin, Hoboken.
 Demund, Cornelius A., Ridgewood, Bergen Co.
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 Denner, Edward F., 221 Broadway, Paterson.
 Dennis, John, 287 Belleville av., Newark.
 De Silver, Jos. F., Galbraith Apart., Atl. City.
 De Vausney, Winfield S., 102 Central av., Newark.
 Devlin, Frank, 90 Congress, Newark.
 Dey, Addison H., 430 E. State, Trenton.
 Diamant, E. L., Bridgeton, Cumberland Co.
 Dias, Joseph L., 91 So. 9th, Newark.
 Dickinson, Ernest L., 100 Greenwood av., Trent'n.
 Dickinson, Gordon K., 278 Montgomery, J. City.
 Dieffenbach, Rich. G. P., 222 S. Orange av., N'k.
 Dill, Daniel M., 425 S. Orange av., Newark.
 Dinglestedt, Rich. H., 619 Hudson, Hoboken.
 Disbrow, Edwin C., Toms River, Ocean Co.
 Disbrow, Rem Lefferts, Toms River, Ocean Co.
 Disbrow, Vanderhoef M., Lakewood, Ocean Co.
 Disbrow, William S., 151 Orchard, Newark.
 Diverty, Henry B., Woodbury, Gloucester Co.
 Dix, J. Morgan, Cape May C. H., Cape May Co.
 Dodd, Samuel W., 60 Carleton, East Orange.
 Dodge, Walter, 32 Cleveland, Orange.
 Dodson, Louis W., 660 Jersey av., Jersey City.
 Dolan, Thomas E., 250 First av., Elizabeth.
 Dolphin, Michael O. F., 112 4th, Harrison.
 Donohue, Frank B., 389 Main, Paterson.
 Donohue, Frank M., 139 Albany, New Brunswick.
 Donohue, Lucius F., 33 Dodge, Bayonne.
 Donovan, Alfred Q., 132 E. Jersey, Elizabeth.
 Dorris, H. Stokes, 119 So. Car. av., Atlantic City.
 Dougherty, Arthur C., 158 Washington, Newark.
 Douglas, James, Maple av., Morristown.
 Douglas, John S., Tuckahoe, Cape May Co.
 Doyle, Lawrence D., Woodbridge, Middlesex Co.
 Drake, Francis J., Phillipsburg, Warren Co.
 Drummond, Edward A., 431 Seventh av., Newark.
 Dubell, J. Eldridge, Columbus, Burlington Co.
 Duffield, Elias M., Glassboro, Gloucester Co.
 Duncan, Owsley B., Haledon, Passaic Co.
 Dundon, Arthur H., North Plainfield.
 Dunkel, Edwin K., 264 Montgomery, Jersey City.
 Dunlap, Mary J., Vineland, Cumberland Co.
 Dunlap, Thomas G., 921 Pacific av., Atlantic City.
 Dunn, Fred V., 623 S. Third, Camden.
 Dunning, Charles M., Franklin, Sussex Co.
 Dunning, Walter L., 533 River, Paterson.
 Duryee, John L., 436 High, Newark.
 Eagleton, Wells P., 15 Lombardy, Newark.
 Eaton, Alvin R. Jr., 1157 E. Jersey, Elizabeth.
 Edwards, J. Gaunt, Williamstown, Gloucester Co.
 Edwards, Sarah M., 207 Summer av., Newark.
 Ellis, Alfred L., Main, Metuchen, Middlesex Co.
 Elmer, Henry W., Bridgeton, Cumberland Co.
 Elmer, Matthew K., Bridgeton, Cumberland Co.
 Elmer, William, 44 W. State, Trenton.
 Elsing, Henry C., Ridgefield, Bergen Co.
 Elwell, Alfred M., 407 Cooper, Camden.
 Ely, Lancelot, Flanders, Morris Co.
 Emerson, Linn, 234 Main, Orange.
 Endicott, George W., Seventh, Plainfield.
 English, David C., 363 George, New Brunswick.
 English, David E., Millburn, Essex Co.
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 Enright, James G., 207 York, Jersey City.
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 Evans, Britton D., Morris Plains, Morris Co.
 Everitt, Chauncey V., 38 Boyd av., Jersey City.
 Everitt, John R., 38 Boyd av., Jersey City.
 Ewen, Warren L., Alloway, Salem Co.
 Ewens, Arthur E., 1512 Pacific av., Atl. City.
 Ewing, John H., Flemington, Hunterdon Co.
 Ewing, S. Eldridge, Leesburg, Cumberland Co.
 Exton, Jas. A., 75 Beach, Arlington, Hudson Co.
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 Faison, William F., 490 Jersey av., Jersey City.
 Farr, J. C. Jr., 1233 Garden, Hoboken.
 Farrow, J. Willard, Dover, Morris Co.
 Farrow, Levi, Hackettstown, Warren Co.
 Fayerman, Walter B., 29 N. Ohio av., Atl. City.
 Fee, Edwin K., Lawrenceville, Mercer Co.
 Felty, John C., P. O. Box 258, Trenton.
 Ferguson, B. W., Beemerville, Sussex Co.
 Fewsmith, Joseph, 47 Central av., Newark.
 Fewsmith, Joseph L., 76 Central av., Newark.
 Field, Edwin, Red Bank, Monmouth Co.
 Finke, Charles H., 315 York, Jersey City.
 Finn, J. Frederick, 157 Danforth av., Jersey City.
 Finn, Joseph F., 157 Danforth av., Jersey City.
 Fischer, Arnim, 539 High, Newark.
 Fischer, George, 90 Auburn, Paterson.
 Fish, C. M., Pleasantville, Atlantic Co.
 Fisher, Claudius R. P., Bound Brook.
 Fisler, C. Frank, Clayton, Gloucester Co.
 Fitch, Thomas S. P., 14 Prospect, East Orange.
 Fitch, George W. H., Daretown, Salem Co.
 Fithian, George W., 195 High, Perth Amboy.
 Fithian, Joel W., 608 Broadway, Camden.
 Flagge, Frederick W., Rockaway, Morris Co.
 Fliteroft, William, 510 River, Paterson.
 Flood, G. Balleray, 115 Broadway, Paterson.
 Flynn, John J., Mt. Holly, Burlington Co.
 Flynn, Thomas H., Somerville, Somerset Co.
 Fogg, Edward S., Bridgeton, Cumberland Co.
 Foley, Michael F., 710 Hudson, Hoboken.
 Fopeano, Joseph L., 265 Fourth, Hoboken.
 Forman, Archibald C., 41 32d, Bayonne.
 Forman, D. McLean, Freehold, Monmouth Co.
 Forman, Howard S., 103 Jewett av., Jersey City.
 Foster, George H., Rockaway, Morris Co.
 Foster, W. Story, 111 Bloomfield av., Newark.
 Frace, P. W., 106 Eleventh, Hoboken.
 Francis, Richard P., 12 Plymouth, Montclair.
 Franckle, C. S., Millville, Cumberland Co.
 Frank, M. G., Egg Harbor, Atlantic Co.

- Franklin, George H., Hightstown, Mercer Co.
 Franklin, Louis, 125 Palisade av., Jersey City.
 Frederick, Gustav H., 349 Camden, Newark.
 Freeland, Frank, Maywood, Bergen Co.
 Freeman, Richard D., 52 Vose av., So. Orange.
 Friedman, Aaron, 112 Park av., Hoboken.
 Friele, William, 203 Palisade av., Jersey City.
 Fritts, John T., 423 Park av., Plainfield.
 Fulper, Theodore B., Junction, Hunterdon Co.
 Funk, Joseph, 615 Elizabeth av., Elizabeth.
 Funkhauser, Edw. B., P. O. Box 258, Trenton.
 Fyfe, George D., 540 Bramhall av., Jersey City.
 Gage, Ruel S., 17 Gould av., Newark.
 Gale, George Bancroft, Rutherford, Bergen Co.
 Gamson, Emil, 41 W. 24th, Bayonne.
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 Garrison, Daniel, Pennsgrove, Salem Co.
 Garrison, Joseph E., Ocean City, Cape May Co.
 Garside, Charles Z., 130 Garside St., Newark.
 Gaston, Mary E., Somerville, Somerset Co.
 Gaston, W. F., 535 W. Front, Plainfield.
 Gauch, William, 199 High, Newark.
 Gehring, G. P., Bakersville, Atlantic Co.
 Gelbach, Rudolphus W., 809 Hudson, Hoboken.
 Geyer, George W., Cape May C. H., Cape May Co.
 Giberson, W. H., Beverly, Burlington Co.
 Gifford, T. Franklin, Woodbury, Gloucester Co.
 Gilbert, James S., Bordentown, Burlington Co.
 Gilchrist, Charles A., 916 Hudson, Hoboken.
 Gille, Hugo, 149 Congress, Jersey City.
 Gillson, John T., 391 Main, Paterson.
 Gillson, Michael W., 11 Lee Pl., Paterson.
 Gilman, Robert B., 85 Congress, Jersey City.
 Glazebrook, Francis H., 106 South, Morristown.
 Glendon, Walter P., Cedarville, Cumberland Co.
 Gluckman, Isaac E., 70 Wickliffe, Newark.
 Godfrey, E. L. B., 400 Linden, Camden.
 Goldberg, E. H., 238 Kearny av., Kearny.
 Good, William T., Bridgeton, Cumberland Co.
 Goodwin, William M., 70 Congress, Newark.
 Gordon, Altamont L., Burlington.
 Gordon, Clark H., 930 E. Statc, Trenton.
 Gordon, Edward J., 925 Clinton, Trenton.
 Gorton, Eliot, Summit, Union Co.
 Graves, William B., 426 Main, East Orange.
 Gray, Frank D., 79 Summit av., Jersey City.
 Gray, Thomas N., 224 Main, East Orange.
 Green, James S., 463 N. Broad, Elizabeth.
 Green, William S., 73 Paterson, Paterson.
 Greenbaum, Solomon, 142 W. Kinney, Newark.
 Greenfield, B. A., 205 S. Orange av., Newark.
 Greenwood, Nathaniel S., Rosenhayn, Cumberland Co.
 Gregory, T. M., La Vence, Park ave., Englewood, Bergen Co.
 Grier, Clarence R., 821 S. Fifth, Camden.
 Grier, Edgar B., 1145 E. Jersey, Elizabeth.
 Griffith, John H., Phillipsburg, Warren Co.
 Griffiths, Chauncey B., 145 Monmouth, Newark.
 Grim, Francis S., Baptistown, Hunterdon Co.
 Griswold, James B., 176 South, Morristown.
 Gross, Herman D., Metuchen, Middlesex Co.
 Guenther, Emil A., 159 W. Kinney, Newark.
 Guion, Edward, 1408 Atlantic av., Atlantic City.
 Gutmann, Benjamin, 418 George, New Brunswick.
 Hagar, John F., 88 Ferry, Newark.
 Hagen, Charles W., 224 S. Orange av., Newark.
 Hagerty, John F., 30 Wallace Pl., Newark.
 Hagerty, Frederick W., Vienna, Warren Co.
 Hagney, Frederick W., 67 Penn. av., Newark.
 Haines, Edward E., 134 David, South Amboy.
 Haines, Eleanor, 934 Broad, Newark.
 Haines, J. Clifford, Vincentown, Burlington Co.
 Haines, J. Ridgway, Mt. Holly, Burlington Co.
 Haines, Roland I., 3d and Kaighn av., Camden.
 Haines, Willets P., Medford, Burlington Co.
 Halbeisen, William J., 919 S. 5th, Camden.
 Haley, John J., Gloucester, Camden Co.
 Hall, W. E., Burlington.
 Hallett, Fred. S., Hackensack, Bergen Co.
 Halsey, Levi W., 49 Church, Montclair.
 Halsey, Luther M., Williamstown, Gloucester Co.
 Hamill, Edward H., 230 Roseville av., Newark.
 Hanan, James T., 200 Claremont av., Montclair.
 Hance, Irwin H., Lakewood, Ocean Co.
 Hand, Anna M., Cape May City, Cape May Co.
 Hand, Leslie L., Millville, Cumberland Co.
 Harbert, G. Eugene, 540 Main, East Orange.
 Hardenberg, Daniel S., 354 Pac. av., Jersey City.
 Haring, John J., Tenafly, Bergen Co.
 Harmon, William J., 1162 E. State, Trenton.
 Harreys, C. W., Ridgewood, Bergen Co.
 Harris, Frank, 214 N. Warren, Trenton.
 Harris, F. B., Canton, Salem Co.
 Harris, Philander A., 26 Church, Paterson.
 Harrison, Joseph B., Westfield, Union Co.
 Haskings, Arthur P., 318 Montgomery, Jer. City.
 Hart, Edward P., 316 Montgomery, Jersey City.
 Hart, Hugh M., 16 Gouverneur, Newark.
 Harvey, Edwin H., 20 N. Fla. av., Atlantic City.
 Harvey, Thomas W., 463 Main, Orange.
 Haussling, Francis R., 661 High, Newark.
 Haven, Samuel C., 7 Maple av., Morristown.
 Havens, Walter P., Farmingdale, Monmouth Co.
 Hawke, Edward S., 124 E. Hanover, Trenton.
 Hawkes, E. Zeh., 15 Central av., Newark.
 Haydon, John H., 22 Brientnall pl., Newark.
 Hecht, John P., Somerville, Somerset Co.
 Hecht, Max, 324 Shippen, West Hoboken.
 Hedges, B. Van Doren, 703 Watchung av., Plainfield.
 Hedges, Ellis W., 703 Watchung av., Plainfield.
 Heintzleman, Bert S., 43 W. 33d, Hoboken.
 Helfer, Samuel A., 626 Hudson, Hoboken.
 Hemsath, John, 36 Spruce, Newark.
 Hendrickson, Daniel D., Middletown.
 Hendrickson, Henry A., Atlantic Highlands.
 Henggeler, Jacob H., 47 Bridge, Paterson.
 Henion, E. Lucas, 16 Church, Paterson.
 Henriques, Henry A., 170 South, Morristown.
 Henry, Frank C., 134 State, Perth Amboy.
 Hepburn, William M., Freehold, Monmouth Co.
 Heritage, Charles C., Glassboro, Gloucester Co.
 Herold, Herman C. H., 77 Congress, Newark.
 Heron, Alexander M., Lakewood, Ocean Co.
 Hetherington, Wm. L., 299 Varick, Jersey City.
 Hewlings, Isaac W., Moorestown, Burlington Co.
 Hickman, Walter A., 612 Pacific av., Atl. City.
 Hicks, William H., 425 S. Orange av., Newark.
 Hill, Christopher S., 102 Grand, Jersey City.
 Hillegas, Eugene Z., Mantua, Gloucester Co.
 Hinckley, Livingston S., 182 Clinton av., Newark.
 Hires, Nathaniel S., Salem, Salem Co.
 Hirst, Levi B., 586 Federal, Camden.
 Hoagland, B. W., Barron av., Woodbridge.
 Hoagland, Garret C., Keyport, Monmouth Co.
 Hoagland, L. B., Oxford, Warren Co.
 Hoell, Conrad G., 565 Benson, Camden.
 Hoening, Charles E., 606 Hudson, Hoboken.
 Hoffman, Peter, 209 Pavonia av., Jersey City.
 Holcombe, Charles H., 41 W. State, Trenton.
 Holden, Edgar Jr., 13 Central av., Newark.
 Holler, Henry B., 201 Verona av., Newark.
 Hollingshead, Enoch, Pemberton, Burlington Co.
 Hollingshead, Irving W., 123 S. 18th, Phila., Pa.
 Hollister, L. Eugene, 138 Clinton av., Newark.
 Holmes, Edwin, Englewood, Bergen Co.
 Holmes, George J., 19 Pennington, Newark.

- Holmes, John C., Cranbury, Middlesex, Co.
Hood, Bruno, Newton, Sussex Co.
Horning, Frank L., 623 Market, Camden.
Horsford, Fred C., Morris Plains, Morris Co.
Houch, William J., 110 Bloomfield av., Newark.
Hough, H. Page, Rahway, Union Co.
Howard, Emory E., Somers Point, Atlantic Co.
Howard, J. Edgar, Haddonfield, Camden Co.
Howard, Joseph T. D., Washington, D. C.
Huger, Joseph, Fort Lee, Bergen Co.
Hughes, Fred. J., North Plainfield, Somerset Co.
Hughes, Morgan D., Layton, Sussex Co.
Hummel, Lester H., Salem, Salem Co.
Hunt, A. Clark, Holly, Metuchen, Middlesex Co.
Hunt, Joseph, Hantsville, Sussex Co.
Hunt, Ralph H., 29 Harrison, East Orange.
Hunter, James Jr., Westville, Gloucester Co.
Hurff, Joseph E., Blackwood, Camden Co.
Husserl, Siegfried, 273 So. 6th, Newark.
Husted, Frank B., Quinton, Salem Co.
Hutchinson, A. Dumbur, 419 Chestnut av., Trenton.
Ill, Charles L., 188 Clinton av., Newark.
Ill, Edward J., 1002 Broad, Newark.
Ingham, S. D., Merchantville, Camden Co.
Ingling, Harry W., Freehold, Monmouth Co.
Ireland, Milton S., 23 S. Cal. av., Atlantic City.
Iszard, William H., 411 N. Fourth, Camden.
Jackson, Andrew J., Matawan, Monmouth Co.
Jacobs, William H., 95 N. Main, Paterson.
Jacobson, Frederick C., 969 Broad, Newark.
Jacquemin, T. J., 192 Bergenline av., Union Hill.
Jacques, J. Eugene, 74 Waverly, Jersey City.
Jaffe, Joseph, Woodbine, Cape May Co.
James, Henry C., Mays Landing, Atlantic Co.
James, William H., Pennsville, Salem Co.
Janeway, Henry H., 17 Livingston av. N. Bruns.
Janney, Joshua D., Cinnaminson, Burlington Co.
Jaquith, Walter A., Broad and Market, Newark.
Jarrett, Harry, Broadway and Cherry, Camden.
Jedel, Meyer, 362 Warren, Newark.
Jenkins, Mozart, 136 Walnut av., Trenton.
Jennings, William B., Haddonfield, Camden Co.
Johnson, Frederick L., Stanton, Hunterdon Co.
Johnson, George L., 21 High, Morristown.
Johnson, Harry T., Pedrickton, Salem Co.
Johnson, John C., Blairstown, Warren Co.
Johnson, Iotham C., 11 Tichenor, Newark.
Johnson, Samuel, Cookman av., Asbury Park.
Johnson, Walter B., 179 Broadway, Paterson.
Jonah, W. E., 1616 Pacific av., Atlantic City.
Jones, Ferdinand, Millville, Cumberland Co.
Jones, J. Morgan, 121 Sip av., Jersey City.
Jones, Ralph R., Toms River, Ocean Co.
Jones, William S., 3d and Penn., Camden.
Joy, J. Addison, 1020 Pacific av., Atlantic City.
Judson, A. R., 29 Union, Montclair.
Judson, William A., 235 Clifton av., Newark.
Kain, William W., Fifth and Pine, Camden.
Kane, Charles J., 349 Grand, Paterson.
Kane, Thomas J., 349 Grand, Paterson.
Kaufman, Ernest, 55 New, Newark.
Keefe, Stephen J., 1061 E. Jersey, Elizabeth.
Keegan, Thomas J., 818 Grand, Jersey City.
Keenan, J. Herbert, 22 W. Jersey, Elizabeth.
Keim, William F., 7 Roseville av., Newark.
Kelchner, Wm. Irwin, 945 Cooper, Camden.
Keller, Frank J., 379 Totowa av., Paterson.
Kensinger, William, 723 N. 27th, Camden.
Kent, George R., 37 Eighth av., Newark.
Kimball, Paul T., Lakewood, Ocean Co.
Kinch, Frederick A., Westfield, Union Co.
Kice, Henry W., Wharton, Morris Co.
Kinmouth, Wm. R., Farmingdale, Monmouth Co.
Kip, Henry, 90 Fair, Paterson.
Kipp, Charles J., 560 Broad, Newark.
Kirk, Grant E., 1801 Broadway, Camden.
Kirkman, Leroy G., 256 Orange, Newark.
Kirsten, A. John, 287 Varick, Jersey City.
Kitchen, Joseph M. W., 94 Prospect, East Orange.
Klein, Maurice I., 127 Wickliffe, Newark.
Kline, William, Phillipsburg, Warren Co.
Knapp, Louis C., Hackensack, Bergen Co.
Knecht, Cyrus, Matawan, Monmouth Co.
Knight, S. R., Spring Lake, Monmouth Co.
Knowles, Francis E., 162 S. Orange av., S. Orange.
Koch, Louis A., 29 Orchard, Newark.
Korneman, Henry A., 262 15th av., Newark.
Korngut, Samuel, 116 Bond, Elizabeth.
Kudlich, William L., 408 Hudson, Hoboken.
Kuehne, Richard, 1118 Summit av., Jersey City.
Kumpf, Reba Lloyd, Bridgeton, Cumberland Co.
Kyte, Calvin F., Garrison and Sip av., Jer. City.
Laird, George S., Westfield, Union Co.
Lake, William A., Cold Spring, Cape May Co.
Lalor, William S., 220 N. Warren, Trenton.
Lambert, Fred. W., 157 Ocean av., Jersey City.
Lamont, George F. M., 202 Clinton av., Newark.
Lampson, Mortimer, 322 Pacific av., Jersey City.
Lane, Frank B., 528 Main, East Orange.
Lansing, James B. W., Tenaflly, Bergen Co.
LaRiew, F. J., Washington, Warren Co.
Lawrence, Alfred, 1086 Elizabeth av., Elizabeth.
Laws, George C., Paulsboro, Gloucester Co.
Leach, Alonzo L., Cape May City, Cape May Co.
Leal, John L., 661 E. 18th, Paterson.
Leaming, Jonathan, Cape May, C. H.
Leaver, Morris H., Quakertown, Hunterdon Co.
Leavitt, John F., 522 N. Third, Camden.
Lee, B. R., 901 Pacific av., Atlantic City.
Lee, Stephen G., 25 Halsted, Orange.
Le Fevre, Adriente, Blackwood, Camden Co.
Lehlbach, Charles F., 537 High, Newark.
Leidy, Edward D., Flemington, Hunterdon Co.
Leonard, Isaac E., 28 N. Iowa av., Atlantic City.
Levy, Julius, 301 Hunterdon, Newark.
Lewis, Alfred A., 102 South, Morristown.
Lewis, George Rae, 481 Summer av., Newark.
Leyenberger, Samuel B. W., 98 Third av., New'rk.
Limburner, Chas. A., 79 Danforth av., Jer. City.
Lindley, C. L., Lakewood, Ocean Co.
Lippincott, A. Haines, 21 Broadway, Camden.
Lippincott, Jesse D., 304 Summer av., Newark.
Litchfield, Paul N., Mt. Ephraim and Kaighn av., Camden.
Livengood, Horace R., 1105 E. Jersey, Elizabeth.
Livengood, Theo. F., 1105 E. Jersey, Elizabeth.
Lockwood, Frank W., 237 Prospect, E. Orange.
Loeb, Arthur A., 347 Littleton av., Newark.
Long, Herbert W., 102 Jefferson, Newark.
Long, Isaac S., Freehold, Monmouth Co.
Long, Monroe D., 415 Park av., Plainfield.
Long, William H. Jr., Somerville, Somerset Co.
Loper, John C., Bridgeton, Cumberland Co.
Loughnan, Andrew J., 136 Bowery, Newark.
Lowere, Thomas W., 30 Hill, Newark.
Lowrey, James H., 79 Congress, Newark.
Lowy, Otto, 62 Beacon, Newark.
Lucas, Henry H., 192 Van Houten, Paterson.
Luffbary, M. Jones, Glassboro, Gloucester Co.
Lummis, Marshall F., Holly Beach, Cape May Co.
Lund, John L., 181 High, Perth Amboy.
Luther, Calista V., 151 Scotland rd., So. Orange.
Lyon, Leslie C., Magnolia, Camden Co.
McAlister, Alexander, 582 Federal, Camden.
McBride, Andrew F., 397 Main, Paterson.
McClendon, Caesar P., 48 Fair, Paterson.
McCloughan, Harvey J., Newton, Sussex Co.

- McClure, James C., Williamstown, Gloucester Co.
 McConnell, J. K., Cranford, Union Co.
 McCormick, Daniel L., 253 Mulberry, Newark.
 McCormick, Henry D., Verona, Essex Co.
 McCoy, John C., 292 Broadway, Paterson.
 McDede, Frank, 908 Main, Paterson.
 McElhinney, Dennis, 626 Elizabeth av., Elizabeth.
 McEwen, Floy, 299 Belleville av., Newark.
 McFadden, Howard, Hackensack, Bergen Co.
 McGill, John D., 124 Mercer, Jersey City.
 McGlennon, Wm. B., 310 Central av., E. Newark.
 McGuire, James, 330 S. Broad, Trenton.
 McKenzie, Thomas H., 528 E. State, Trenton.
 McKenzie, William H., 942 Broad, Newark.
 McLaughlin, George E., 41 Crescent av., Jer. City.
 McLoughlin, Thos. J., 558 Jersey av., Jersey City.
 McLean, John J., 430 Hoboken av., Jersey City.
 McLean, Thomas N., 1144 E. Broad, Elizabeth.
 McNamara, Thomas C., 715 Park av., Hoboken.
 McWilliam, John F., Somerville, Somerset Co.
 MacAlister, W. Wallace, 21 Church, Paterson.
 Macintosh, M. Alex., 237 Broadway, Paterson.
 Maclay, Joseph A., 239 Broadway, Paterson.
 MacMillan, George W., Lakewood, Ocean Co.
 Macwithey, Amasa A., Riverdale, Morris Co.
 Madden, E. H., Absecon, Atlantic Co.
 Madden, T. H., Collingswood, Atlantic Co.
 Madden, Walter, 324 S. Broad, Trenton.
 Madison, Keim, Augusta M., 188 Roseville av., Newark.
 Magennis, Bryan C., 81 Bridge Paterson.
 Maghee, James M., 7 Main, West Orange.
 Mahaffey, Jessie L., Seventh and Elm, Camden.
 Mallalieu, Frank W., 62 Monticello av., Jer. City.
 Mallon, Peter S., Morris Plains, Morris Co.
 Mander, A. J., Millville, Cumberland Co.
 Marcy, Alexander, Riverton, Burlington Co.
 Marcy, Alexander, Jr., Riverton, Burlington Co.
 Marcy, Frederick W., Sixth and Penn., Camden.
 Marcy, John W., Merchantville, Camden Co.
 Marcy, Virgil M. D., Cape May, Cape May Co.
 Markley, Paul H., 515 Cooper, Camden.
 Marks, Edward G., Elshermius, Arlington.
 Marsh, Elias J., 600 Park av., Paterson.
 Marsh, Elias J., Jr., 24 Church, Paterson.
 Marshall Jos. C., 1517 Pacific av., Atlantic City.
 Marshall, Joseph C., Tuckahoe, Cape May Co.
 Marshall, Randolph, Tuckahoe, Cape May Co.
 Martin, Thaddeus P., 46 Springs, Trenton.
 Martin, William, Bristol, Pa.
 Martindale J. Watson, 2303 Federal, Camden.
 Martinetti, Carlo, 139 Center, Orange.
 Martland, William H., 1138 Broad, Newark.
 Marvel, Emery, 811 Pacific av., Atlantic City.
 Marvel, Philip, 1616 Pacific av., Atlantic City.
 Matthews, Henry E., 12 Hillside av., Orange.
 Matthews, William J., 1009 Garden, Hoboken.
 Mayhew, Charles H., Millville, Cumberland Co.
 Mayhew, Samuel D., Bridgeton, Cumberland Co.
 Meacham, Eugene A., 120 David, South Amboy.
 Mead, Sarah R., 16 James, Newark.
 Mecray, James, Cape May City, Cape May Co.
 Mecray, Paul M., 405 Cooper, Camden.
 Megaro, Panerazio M., 313 High, Newark.
 Meeker, Frank B., 63 First st., Newark.
 Meigh, Josiah, Bernardsville, Somerset Co.
 Melcher, W. P., Mt. Holly, Burlington Co.
 Mendenhall, C. D., Bordentown, Burlington Co.
 Menk, Paul E., 29 13th av., Newark.
 Mercell's, Elizabeth, 17 Plymouth, Montclair.
 Mercer, Archibald, 31 Washington, Newark.
 Merrill, Charles F., 207 Central, Newark.
 Merrill, John R., 15 Church, Paterson.
 Merrill, William H., South Branch, Somerset Co.
 Merrins, Edward M., 29 William, East Orange.
 Metzger, Emma P. W., Riverside, Burlington Co.
 Metzler, Victor W., LeGrand Apart., Atl. City.
 MeVey, J. C., 707 Pacific av., Atlantic City.
 Meyer, W., 446 Clinton av., West Hoboken.
 Mial, Leonides L., Morristown, Morris Co.
 Miller, H. Garrett, Millville, Cumberland Co.
 Miller, J. N., Newton, Sussex Co.
 Miller, William E., 8th and Mt. Vernon, Camden.
 Mills, Andrew M., 122 Washington, Newark.
 Mills, Clifford, 11 De Hart, Morristown.
 Millsbaugh, Daniel T., 43 Totowa av., Paterson.
 Mines, Marcus K., 532 West, Camden.
 Mitchell, Augustus J., 71 South, Newark.
 Mitchell, Charles H., 116 Centre, Trenton.
 Mitchell, Henry, 1201 Grand av., Asbury Park.
 Mitchell, Winthrop D., 23 S. Grove, East Orange.
 Moenig, Joseph A., Park Ridge, Bergen Co.
 Montfort, Robert J., 1051 East Jersey, Elizabeth.
 Mooney, John J., 554 Jersey av., Jersey City.
 Moore, Edward H., Asbury, Warren Co.
 Moore, George R., 259 Hamilton av., Trenton.
 Moore, John, Sussex, Sussex Co.
 Moore, John D., Bloomfield, Essex Co.
 Moore, John H., Bridgeton, Cumberland Co.
 Moore, W. M., 79 Livingston av., N. Brunswick.
 Morrill, James P., 10 Church, Paterson.
 Morris, Clement, 75 Washington av., Newark.
 Morrison, Daniel L., 50 Paterson, N. Brunswick.
 Morrison, John B., 97 Halsey St., Newark.
 Morrison, Ephraim, Newton, Sussex Co.
 Mravlag, Victor, 1062 E. Jersey, Elizabeth.
 Mulvaney, Edward, 487 Jersey av., Jersey City.
 Murray, Eugene W., 493 Summer av., Newark.
 Murray, Wm. H., 737 Watchung av., Plainfield.
 Muta, Samuel A., Park av., West Orange.
 Muttart, George W., 702 Ocean av., Jersey City.
 Nadler, Frederick C., 31 Green, Newark.
 Nalitt, David I., 22 E. 22nd., Bayonne.
 Nash, Alfred B., Frenchtown, Hunterdon Co.
 Nash, Albert B., 10 S. 13th, Newark.
 Neale, Charles B., Millville, Cumberland Co.
 Neare, Clifford R., 2 Hawthorne av., E. Orange.
 Neer, Henry C., Park Ridge, Bergen Co.
 Neer, Rush, 95 Bridge, Paterson.
 Neer, William, 87 Fair, Paterson.
 Nelson, A., 105 Grand, Jersey City.
 Nevin, John, Boul. and Kensington av., Jer. City.
 Newcombe, Marcus W., Burlington.
 Newman, Emanuel D., 81 New, Newark.
 Newton, Anne B., 137 S. Orange av., So. Orange.
 Newton, Richard C., 42 Church, Montclair.
 Newton, William K., 379 Ellison, Paterson.
 Nicholson, Joseph L., 400 Penn., Camden.
 Noble, Willis C., 55 S. Fullerton av., Montclair.
 Nolte, Henry W., 255 Mulberry, Newark.
 North, Harry R., 284 Hamilton av., Trenton.
 North, James, 29 S. Tenn. av., Atlantic City.
 Norton, Horace G., 429 E. State, Trenton.
 Norval, William A., 419 Main, Paterson.
 O'Connor, J. F., 35 Kearny av., Kearny, Hudson.
 O'Donnell, James, 82 Ward, Paterson.
 Oestman, August W., 961 Summit av., Jersey City.
 Ogden, B. Frank, Clayton, Gloucester Co.
 O'Grady, Thomas F., 374 Grand, Paterson.
 Oliphant, Eugene T., Bridgeport, Gloucester Co.
 Oliphant, Nelson B., 152 W. State, Trenton.
 Oliver, David H., Bridgeton, Cumberland Co.
 Opdyke, Ralph, 27 S. Fullerton av., Montclair.
 O'Reilly, Edward R., 167 Second, Elizabeth.
 Osmun, Louis C., Hackettstown, Warren Co.
 Osmun, Milton M., 815 Broadway, Camden.
 Owen, Frederick W., 48 South, Morristown.
 Paganelli, T. Richard, 401 Monroe, Hoboken.

- Palm, Howard F., 614 N. Second, Camden.
 Parke, Henry, 9 Church, Paterson.
 Parker, E. E., Pacific, cor. Pa. av., Atl. City.
 Parker, George H., 420 E. State, Trenton.
 Parker, William J., 604 Bergen av., Jersey City.
 Parry, William C., Hainesport, Burlington Co.
 Parsell, Louis B., Closter, Bergen Co.
 Parsonette, Peter, 132 W. Kinney, Newark.
 Parsons, John C., 311 York, Jersey City.
 Parsons, Richard H., Mt. Holly, Burlington Co.
 Partree, R. T., Eatontown, Monmouth Co.
 Paul, Frederick M., 562 High, Newark.
 Paxton, John P., 16 Church, Paterson.
 Payne, Joseph, Midland Park, Bergen Co.
 Pechin, Edward C., 311 N. Third, Camden.
 Peck, Edward E., Caldwell, Essex Co.
 Pellet, J. B., Hamburg, Sussex Co.
 Pelouze, Percy S., 671 Springfield av., Newark.
 Pennington, William, Basking Ridge.
 Perkins, James L., Cranford, Union Co.
 Petry, William, 325 So. Orange av., Newark.
 Pettis, Albert, 49 Somerset, Plainfield.
 Pettit, Alonzo, 116 W. Grand, Elizabeth.
 Pezze, Luigi, 280 Fourth, Jersey City.
 Phelan, E. S., 18 South St., Newark.
 Philhower, George P., Nutley, Essex Co.
 Phillips, Cyrus B., Hurffville, Gloucester Co.
 Physick, Emlen, Cape May City, Cape May Co.
 Pierson, Frederick H., 440 N. Broad, Cranford.
 Pierson, Henry C., Roselle, Union Co.
 Pierson, H. Morton, Roselle, Union Co.
 Pierson, L. A., Hopewell, Mercer Co.
 Pierson, Stephen, 70 South, Morristown.
 Pike, Horace V., 144 Hamilton av., Paterson.
 Pinder, David S., 201 Garden, Hoboken.
 Pinneo, Frank W., 199 Garside, Newark.
 Piskorski, Abdon V., 261 5th St., Jersey City.
 Pittenger, Charles R., 82 Congress, Newark.
 Pittis, Godfrey, Allendale, Bergen Co.
 Pittis, Harold, Lakehurst, Ocean Co.
 Pollak, B. S., 241 Grove, Jersey City.
 Pollard, Joseph E., Chatham, Morris Co.
 Pollard, Wm. M., 25 S. So. Car. av., Atl. City.
 Poole, Louis, 521 Palisade av., West Hoboken.
 Poor, D. W., 27 Ridge St., Orange.
 Porteous, E. J., 811 Pacific av., Atlantic City.
 Porter, Katherine, 149 William, Orange.
 Potter, Palmer A., 469 Main, East Orange.
 Potter, Robert C., 34 Centre, Newark.
 Powell, William R., 702 Market, Camden.
 Pratt, John E., Dumont, Bergen Co.
 Pratt, William H., 406 N. Sixth, Camden.
 Presley, Sophia, 323 N. Fourth, Camden.
 Price, Franklin C., Imlaystown, Monmouth Co.
 Price, J. C., Branchville, Sussex Co.
 Price, Nathaniel G., 62 Boston, Newark.
 Price, Theophilus T., Tuckerton, Ocean Co.
 Prickett, Elmer D., Mt. Holly, Burlington Co.
 Probasco, John B., 175 E. Front, Plainfield.
 Probasco, Norman H., Plainfield.
 Proctor, James W., Englewood, Bergen Co.
 Prout, Thomas P., Summit, Union Co.
 Pulsford, Henry A., 139 S. Orange av., S. Orange.
 Purdy, Chas. H., 312 Montgomery, Jersey City.
 Pyle, Immanuel, 54 Monticello av., Jersey City.
 Pyle, Wallace, 713 Bergen av., Jersey City.
 Quinby, William O'G., 80 Columbia, Newark.
 Quinn, Stephen T., 125 Jefferson av., Elizabeth.
 Rafferty, P. J., Red Bank, Monmouth Co.
 Ramsdell, Ernest S., 423 Linden, Camden.
 Ramsey, Murray E., 402 Arlington av., Jer. City.
 Ramsey, William E., 103 High, Perth Amboy.
 Randall, Charles H., 50 Third av., Newark.
 Randolph, John M., 131 Main, Rahway.
 Ranson, Briscoe B., Jr., Maplewood, Essex Co.
 Read, Clinton H., S. Warren and Fall, Trenton.
 Read, James J., Sea Bright, Monmouth Co.
 Read, Joshua W., 82 Park place, Newark.
 Reading, Geo. E., Woodbury, Gloucester Co.
 Reason, John J., Carteret, Union Co.
 Rector, Joseph M., 307 York, Jersey City.
 Reddan, Martin W., 113 W. State, Trenton.
 Reed, Eugene L., 920 Pacific av., Atlantic City.
 Reed, Talbot, 104 S. Rhode Island av., Atl. City.
 Reed, Thomas K., 22 N. Penn. av., Atlantic City.
 Reese, James M., Phillipsburg, Warren Co.
 Reich, S. A., 118 Bowers, Jersey City.
 Reiley, Edward A., 20 S. Tenn. av., Atl. City.
 Reilley, Harrie M., 94 Maple av., Morristown.
 Reilly, John P., 215 Elizabeth av., Elizabeth.
 Reynolds, Walter, 27 S. Indiana av., Atlantic City.
 Ribban, R. C., 63 Central av., Newark.
 Rice, J. Warren, 304 George, New Brunswick.
 Richardson, Emma M., 581 Stevens, Camden.
 Richman, Edward M., 252 Mulberry, Newark.
 Ricord, Philip, 268 Bank, Newark.
 Ridgeway, Wm. F., Atlantic av., Atlantic City.
 Ridgeway, George M., 140 W. State, Trenton.
 Riggins, Edwin N., 225 Midland av., E. Orange.
 Riordan, John, Carlstadt, Bergen Co.
 Risk, J. Boyd, Summit, Union Co.
 Ritter, John J., 16 Smith, Paterson.
 Riva, Ferdinand E., Main St., Milltown.
 Roberts, Edgar, Keyport, Monmouth Co.
 Robertson, Samuel E., 21 Walnut, Newark.
 Robinson, Benjamin D., 265 Mulberry, Newark.
 Robinson, S. E., Waldwick, Cumberland Co.
 Robinson, Frank Neall, 518 Linden, Camden.
 Robinson, Manning N., 159 Elm, Newark.
 Robinson, William D., 12 S. Grove, East Orange.
 Roden, Hugh P., 345 Washington, Newark.
 Roebz, William J., 24 Monmouth, Newark.
 Rogers, Benj. H., 213 Broadway, Paterson.
 Rogers, Edward B., Collingswood, Camden Co.
 Rogers, Elmer H., 126 N. Warren, Trenton.
 Rogers, George A., 1 Wallace, Newark.
 Rogers, Robert H., 64 South 10th, Newark.
 Rogers, R. R. Sr., 110 E. Hanover, Trenton.
 Rogers, Richard R., Jr., 610 Perry, Trenton.
 Romine, George L., Lambertville, Hunterdon Co.
 Rose, Horace L., 9th and Federal, Camden.
 Rosenkrans, James H., 826 Hudson, Hoboken.
 Rosensohn, William, 310 Dodd, East Orange.
 Rosenstein, A. J., 139 Wayne, Jersey City.
 Rowe, Norman L., 798 Grand, Jersey City.
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METASTATIC PANOPHTHALMITIS.

By Charles J. Kipp, M. D., Newark, N. J.

Twenty-two years ago I published three cases of metastatic ophthalmia* in each of which the disease was confined to one eye. All of these patients recovered, but with the loss of the eye. In one of these cases puerperal pyaemia was the cause of the eye disease; in the other two a purulent inflammation of the middle ear was the primary disease. Since that time I have not seen a single case of metastatic ophthalmitis in connection with puerperal sepsis, which is doubtless due to the happily increasing rarity of puerperal septic affections. Surgical pyaemia or septic pyaemia is not so rarely met with, but eye disease must rarely occur in connection with it, as I have not seen other cases than those reported, in the various general hospitals with which I am connected and in which the attending surgeons invariably call my attention to cases in which an eye affection is developed while under their care. Although the cases below reported do not present any unusual features, so far as the eye disease is concerned, I believe they are of sufficient interest to the practitioner to warrant their publication.

CASE I. Appendicitis; Phlegmasia alba dolens; Metastatic Panophthalmitis both eyes.

This case was under the care of Dr. Edward Staehlin, to whom I am indebted for the following history:

A woman, 54 years old, married, well nourished, and healthy except occasional at-

tacks of indigestion of a mild degree, was suddenly taken sick 7 A. M. January 27, 1906, with severe pains of a colicky nature in the lower abdominal region, associated with painful and frequent micturition. These pains were located at the McBurney point. Rectal temp. 101, pulse 80. There was constipation and eructation of gas, no flatus. Renal colic was excluded because of normal condition of urine. Localized tenderness, elevation of temperature, constipation; and appendicitis was diagnosed because of these symptoms—appendicitis with posterior attachment or involvement, probably in close proximity to ureter.

Operation 5 P. M. on same day, substantiated the diagnosis. The wound was sewed up tight, and a favorable prognosis given. She passed an uneventful week and the dressing was changed; primary union; felt well; ate well, and she was assured she might go home at the end of her second full week. During the night of the eighth day she was sleepless, restless, temperature ran up from 99 4-10 to 102 6-10, pulse 108. Next morning the left leg was very much swollen and painful and by evening a well-marked phlegmasia alba dolens had developed. In nine days her temperature was again normal and remained so until the 10th of March; by this time the limb had become normal in dimensions. She felt well in every way, her digestion was good and we planned for her return home. During the night of the 10th of March the temperature shot up to 104 6-10; she vomited undigested food and had profuse watery stools containing particles of undigested food (12 stools in twenty-four hours). In next twenty-four hours, 4 watery stools. From this time her stools continued loose up to the time

*American Journal of Medical Science, 1884, p. 417.

of her death, March 29. From March 10 to March 14 her temperature had gradually come down from 104.6-10 to 100, then rose again to 104 and from that time, March 14, to March 29 had fluctuated between 101 and 104. The sudden onset of the diarrhoea and the persistence of the watery character made me think of mesenteric emboli. March 14 she complained of very severe pains in her knees which were very agonizing but intermittent; there was no effusion. Blood examination March 18: normal, no streptococci demonstrated, no leucocytosis.

March 18 she developed eye symptoms, first in right eye, a day later in left, the onset was very rapid. Dr. Kipp saw her at this time. She complained of much impairment of sight. The eyelids became red and swollen. The eyeballs began to protrude. The conjunctiva was oedematous. The cornea hazy, the aqueous humor was turbid. The iris was discolored and mostly covered with a purulent exudation. The pupil was small and filled with exudation. The cornea was insensitive. No ophthalmoscopic examination could be made. The left eye was not much protruded and there was not so much swelling of the ocular conjunctiva, but otherwise it was about in the same condition as the right. On the following day she was totally blind. She did not complain of much pain in the eyes. Warm water compresses were applied and a solution of sulphate of atropine 1 per cent. was instilled every three hours. The treatment had, however, no effect whatever on the eyes which continued in about the same condition up to the time of her death—eleven days after the beginning of the ophthalmia. No perforation of sclerotic or cornea occurred. From 18th to 29th March she continued in this condition: Bowels loose, sometimes moved involuntarily; abdomen at times markedly distended; occasional nausea and vomiting. Urine—spec. gr. 1020-1015, trace of albumen and a few hyaline casts. Mind clear at times, alternating with mild delirium. No autopsy could be obtained.

CASE II. Septico-Pyæmia following lacerated wound of foot and leg; acute ulcerative endocarditis; metastatic panophthalmitis of both eyes. Death 45 days after injury.

M. D., an Italian 15 years of age, was admitted to the City Hospital February 25, 1906. Family history negative. Five days before admission his left foot was caught between elevator and platform; foot was badly crushed and bled profusely. The

physician who first saw him sutured wound with catgut. On admission his general condition was fair, the heartbeat rapid and strong. No dullness of lungs, but large and small rales through both lungs; breath sounds roughened. Abdominal organs negative. The left foot was badly crushed, a lacerated wound about two inches in length on inner side of foot which had been tightly closed by catgut sutures some days before by a surgeon outside of the hospital; foot and leg up to knee were swollen and discolored. Temperature 103.4-10, pulse 130, respiration 24. The sutures were removed and incisions made in foot and leg, wet dressing of bisulphite of sodium was applied and the limb put in a right angle splint.

The treatment failed to prevent the spread of the inflammation upwards and it was thought best to make further multiple incisions higher up on March 3. Brewer's yeast was substituted for the bisulphite of sodium dressing, but as it was apparently without effect the former dressing was again applied. By March 20 the disease had extended up to the left buttock and four days later it had spread to the right buttock. He was put under ether and extensive and deep incisions were made in the parts affected, which evacuated large quantities of pus. During this period the patient had been rapidly losing weight and strength. Symptoms of endocarditis were first observed on or about March 24—about thirty-two days after the receipt of the injury. The left eye first showed signs of inflammation on April 7. There was not much injection of the ocular conjunctiva and no swelling of the lids. The cornea was decidedly hazy, the anterior chamber of normal dimensions, the aqueous humor was turbid and the iris was covered with a thick layer of yellowish white exudation, the pupil was small and filled with the same exudation. No ophthalmoscopic examination could be made. The eyes did not seem to give him any pain, but patient was so apathetic at this time that no answer to questions were given. On the following day a very similar condition was found in the right eye. He was totally blind. There was no great change in the appearance of the eyes during the following days. He died four days after the eye affection was first noticed.

An examination of his urine made February 27 showed a trace of albumen, no casts, no sugar. On March 25 the urine was of specific gr. 1010 and contained a large

amount of albumen, and granular casts but no sugar. An examination of his blood made April 9, two days before his death, showed streptococci in cultures. The secretion from his leg also contained streptococci. The temperature rose to 105 3-10 on the day after his admission and during the following week it ranged from 99 to 104; during the next week it fluctuated between 99 3-10 and 104 4-10. During the remainder of his life about the same fluctuations as previously noticed continued. His pulse beats up to a week before his death ranged from 90 to 144, after that time over 160 and four days before his death it was so weak that it could scarcely be felt. The medical treatment consisted of digitalin gr. 1-100, strychnin sulph. gr. 1-40 every three hours. Morphine was given occasionally for the relief of pain. He was fed on milk and eggs and in the last week was given egg-nog freely.

Autopsy, April 12, 1906, by Dr. Charles A. Teeter: Build slight; musculature small; no deformities; left foot badly discolored and misshapen; open wounds in left thigh and leg with thin yellowish pus exuding. Skin—yellowish in color, dry and hard. Hair—scanty, shiny and dry. Teeth were in fairly good condition. Muscles were small and flabby; rigor mortis was absent except in elbows. Panniculus was very scanty, there was no oedema present; body-heat was absent; hypostasis was well marked over back and shoulders. Head was not examined internally. Both eyes: found cornea cloudy, partially collapsed and pus in anterior chambers. Eyes, both removed.

Thorax: Pericardium was not distended; fat somewhat increased. Heart: Auricles distended, filled with fluid, blood and ante-mortem clots; right ventricle slightly enlarged; valves (tricuspid) normal; left ventricle was enlarged; the walls hypertrophied slightly; the mitral valves showed some areas of calcification and the aortic valves several areas of recent ulceration and small areas of calcareous deposits; the valvular flaps were completely ulcerated through in places. Acute ulcerative endocarditis. Lungs showed fresh pleuritic adhesions, tear easily; chronic passive congestion and oedema; a thin yellowish purulent substance in small bronchi; the lungs containing air throughout.

Abdomen: Peritoneum was moist and shiny; fluid not excessive; no adhesions. Spleen was soft and capsule adherent; anaemic infarct size of a silver quarter in

left upper portion; rest of pulp very soft. The kidneys were rather small; fat small in amount; capsules stripped rather easily; cortices slightly atrophic; cloudy swelling and beginning degenerative changes and passive congestion. In pelves small amount of thin watery purulent material, also in pyramids. Beginning pyo-nephrosis. Stomach was distended, containing thin foul smelling material, but there were no pathological changes. Intestines, small and large, negative. Liver was rather large—nutmeg-liver, passive congestion, no infarcts seen, gall bladder—negative.

For the history and the notes of autopsy I am indebted to the House Staff of the City Hospital.

MICROSCOPIC EXAMINATION OF LEFT EYE BY DR. GEORGE S. DIXON.

When the globe was divided an exudate was found in both the anterior and vitreous chambers, which was partially flocculent in character. The greater portion of the exudate within the vitreous chamber was lost during manipulation, and hence does not show in the preparations. The retina was thrown into folds by contraction of the sclera. The lens was found in the posterior portion of the globe embedded in ice (the eye had been frozen) in such a condition and position as to lead us to believe that the dislocation was due to the globe having been allowed to fall, rather than to any pathological process.

Sections show the corneal epithelium in fairly good condition, and Bowman's membrane well marked, but the cornea propria is moderately and evenly infiltrated with small round cells; pannus not present in any of the sections examined. Descemet's membrane is present, but its epithelial lining has disappeared. The iris angle, spaces of Fontana, and canal of Schlemm are obliterated. The anterior chamber contains pus, and a granular exudate with streptococci in large numbers. The iris is swollen and infiltrated with small round cells. The ciliary body and processes are in the same condition, but to a less degree, and a cyclitic membrane is present. The lens, aside from being shrunken and somewhat distorted, is slightly cataractous in the zonular region. The capsule is intact. A purulent exudate surrounds the ciliary processes, and a layer of the same is in contact with the inner surface of the retina.

The inner layers of the retina are in fairly good condition, and the pigmentary layer appears to be intact, but the bacillary layer and the external limiting mem-

brane have undergone granular degeneration and in some locations seem to be somewhat thickened. The choroid is not thickened to any extent, but is filled with small round cells. The sclera shows isolated colonies of small round cells. The sheath of the nerve is thickened, the nerve appears to have been oedematous, and papillitis present. The intervaginal space and nerve also carry numerous small round cells. The infection was due to streptococcus pyogenes longus, the staining reaction of which is peculiar. The germ stains well with Löffler's blue, but does not stain by Gram, nor with dilute Ziehl. We have concluded that this is probably due to the manner of preparation of the globe.

Diagnosis: General uveitis with hypopyon and interstitial keratitis.

Groenouw, in Graefe & Saemisch (Handbuch d. Gesamten Augenheilkunde, 2 te Auflage, Band XI, p. 504) has collected all cases on record of surgical pyaemia in which the eyes were affected. His cases number sixty, of which twenty-six were injuries and operations. As cases of this kind are quite rare and are usually put on record, he thinks that from the following statistical information, derived from his table, a fairly accurate picture may be constructed. The age of the patients varied from one day to sixty-nine years and was on an average thirty-five years. More than one-half of the patients were between twenty and fifty years; one-fourth were more than fifty years old. Among fifty-two persons were forty-one men (79 per cent.), corresponding to the well-known experience that men are more exposed to traumatic injuries leading to pyaemia. The outbreak of the eye disease occurred between the first and forty-fifth day. The course of the eye affection was in no way influenced by its early or late appearance. In the cases ending fatally the duration of the disease was between twelve and one hundred and fifty-three days. On the average it was thirty-six days. Death occurred between the first day and the fifth month after the beginning of the eye disease, on the average on the twenty-fourth day.

Among fifty-three cases there were sixteen bilateral and thirty-seven unilateral cases of ophthalmia. Of the first seventy-five per cent. died, of the latter only fifty-four per cent. The above shows clearly the malignancy of the bilateral cases in surgical pyaemia but not as markedly as in the puerperal form. In the four bilateral cases that survived, the ophthalmia developed in

both eyes at the same time and ended in panophthalmitis. The unilateral ophthalmia was found mostly in mild cases, but not by any means without exception, and the bilateral ones in cases of severe pyaemia. Endocarditis is more rarely found in surgical pyaemia than in the puerperal form. But if we compare only the cases with metastatic ophthalmia in both forms of pyaemia the difference is but slight. Of the persons in whom the ophthalmia was the only metastasis twenty-five per cent. died, and of those with metastasis in other organs eighty-four per cent. succumbed.

With regard to the pathology, Groenouw says: "The metastatic ophthalmia is caused by the entrance of septic masses into the capillaries of the eye and in the bilateral cases it is exclusively or predominantly in the retina, and in the unilateral cases also in the uvea (Axenfeld)." The infectious masses must be mostly very minutely divided, which in other parts can pass freely and are caught in the very narrow capillaries of the retina. The rapid loss of vision is not to be regarded as the result of the embolism, but rather as the effect of a rapidly developing inflammation.

The disposition of the eye for metastases is explained by the narrowness of the capillaries of the retina. (This is also the reason why the ophthalmia is not rarely the only ascertainable metastasis). Other factors are disturbances in the circulation, perhaps the formation of thrombi in the retina and choroid (Axenfeld). The ascertainment made by some writers that the metastatic ophthalmia is due not only to micro-organisms, but can also be produced by the action of toxins is as yet unproved. The absence of bacteria in the microscopical preparation is by no means proof that they were absent during life. A negative result of the examination is of no value also in cases in which the disease has lasted three months. The micro-organisms which have been found in the metastatic ophthalmia are the streptococcus, staphylococcus pyogenes, pneumococcus, and a few not clearly defined bacteria.

DISCUSSION.

Dr. Walter B. Johuson, of Paterson.—Dr. Kipp has covered the subject so thoroughly that there is but little left to say; but still I want to express the appreciation I feel in having heard the report of these cases, for they are rare. Such a condition following appendicitis is very unusual, as it is when following wounds. The pyaemia or septicæmic condition which occurs is generally,

in my experience, due to puerperal pyaemia. I have only seen two cases of this trouble, one occurring from a puerperal pyaemia, the other from an endocarditis. The books state that cerebrospinal meningitis, typhus fever, thrombus of the orbital veins, endocarditis and pleuro-pneumonia have been responsible for this form of infection, but they say very little about the infection occurring from injury or from operation. The bacteriological examination of such cases usually, if the case is a recent one, show in the diseased eyeball the bacteria which are present in diseased conditions of the intestinal tract and elsewhere at the seat of original infection. Some cases may show the pneumococci, others the streptococci and the staphylococci, but not in all cases are found the bacilli of the particular affection. Panophthalmitis is a condition which comes from an infection, due to some particle of infected material being carried through the circulation to the vessels of the eye. There seems to be a difference of opinion as to whether this condition starts in the retinal vessels or the choroidal vessels; whether the infection is through a small embolus or through a thrombus of the choroidal vessels. In these cases if death results, or if enucleation is attempted and this is followed by an extension of the infection, it is afterwards discovered that there is a suppurative meningitis as the original cause of the trouble, there is always some doubt in my mind as to the source of the infection, and whether the meningitis appeared first and infection of the eye followed. But these cases are very rare. They are certainly serious when considered as indicators of the individual's physical condition. Whether idiopathic or directly resulting from an endocardial or suppurative affection of other parts, there is no doubt but that a very serious prognosis should be given.

I am glad to have had this opportunity to say this much.

Dr. Norton L. Wilson, of Elizabeth.—I have to thank Dr. Kipp for bringing this matter before the Society because these cases are exceedingly rare. I have never seen a case following a surgical operation, but I have seen three cases following other diseases. One was a young boy, sixteen years old; his trouble arose from an endocarditis; he lost one eye and lived. The second case was a man forty years old, who contracted mumps. Three weeks after he became suddenly blind and there was a panophthalmitis of the right eye and, a few days later, the left eye became involved and he died. The third case followed a pneumonia. Four days after being taken ill there was a panophthalmitis of the left eye and twenty-four hours later of the right eye. This man died. These cases are very important and should be looked for and kept in mind.

Dr. Theron Y. Sutphen, of Newark.—These cases are not only rare but they are very appalling. I had one very striking case which I saw in Madison fifteen years ago with Dr. Anderson. A man had been sick with cerebrospinal meningitis, the disease having existed two weeks. When I saw him first one eye was affected with what appeared to be a purulent choroiditis; in a few days the other eye became involved. It appeared like a suppuration of the whole globe but did not follow the same course that Dr. Kipp's cases did, with a shrinking of the eyeball. My patient lived and is living to-day. These cases a man will never forget when once seen.

Dr. Charles J. Kipp, of Newark.—I wish to mention that there was a discrepancy between the blood findings and the microscopical examination of the eyes. Before death we found streptococci—at least that was the report of the bacteriologist. An examination of the eye revealed the presence of staphylococci. This has been observed before. I think it was Dr. Councilman who said we should not take the report of one man only, but of several; one man's statement should not be depended upon.

RESULTS OF DR. ALLPORT'S PLAN OF EXAMINATION OF THE EYES AND EARS OF PUBLIC SCHOOL CHILDREN IN THE ORANGES.*

By Linn Emerson, M. D.

Assistant Surgeon to the Manhattan Eye, Ear and Throat Hospital; Oculist and Aurist to the Orange Memorial Hospital.

That the medical inspection of school children is advantageous from all points of view is obvious to every member of this Society.

The many financial and political hindrances are also equally well known. In the early nineties Dr. Frank Allport formulated a plan for the inspection of the eyes and ears of school children by school teachers. He has labored unceasingly for its adoption, and as a result of his efforts, the American Medical Association and many of our State Societies have given his plan official endorsement.

In a recent letter to the *Ophthalmic Record* he calls attention to the fact that Connecticut and Vermont have passed laws covering his plan.

The recently enacted Vermont law reads as follows: SEC. 1. The State Board of Health and the Superintendent of Education shall prepare, or cause to be prepared, suitable test cards, blanks, record books and other needful appliances to be used in testing the sight and hearing of pupils in public schools, and necessary instruction for their use; and the Superintendent of Education shall furnish the same free of expense to every school in the State. The superintendent, principal or teacher in every school during the month of September in each year shall test the sight and hearing of all pupils under his charge, keep a record of such examinations according to the instructions furnished, and shall notify in writing the parent or guardian of every pupil who shall be found to have any defect of vision or hearing, or disease of the

*Read at the 1906 annual meeting of the New Jersey Medical Society.

eyes or ears, with a brief statement of such defect or disease, and shall make a written report of all such examinations to the Superintendent of Education as he may require. SEC. II. The State Auditor is hereby directed to draw his order on the State Treasurer for such sums and at such times as the Superintendent of Education, with the approval of the State Board of Health, may require to carry out the provisions of this act. The total expense under this act shall not exceed Six Hundred Dollars (\$600.00) in any bi-annual term ending June 30. SEC. III. This act shall take effect July 1, 1905.

Sufficient knowledge of the scheme can be obtained by a perusal of the "Directions to the Teachers" and the circular letter sent to parents, which are as follows:

DIRECTIONS TO TEACHERS.

Eye and Ear Test.

I. Do not expose the card except when in use, as familiarity with it leads children to learn the letters "by heart."

II. First grade children need not be examined.

III. The examination should be made privately and singly in a room apart from the general school session.

IV. Ascertain if the pupil habitually suffers from inflamed lids and eyes.

V. Children wearing glasses should be examined with such glasses properly adjusted on the face.

VI. Place the card of test types on the wall in a good light; do not allow the face of the card to be covered by a glass.

VII. The line marked XX (20) should be seen at twenty feet, therefore place the pupil twenty feet from the card.

VIII. Each eye should be examined separately.

IX. Hold a card over one eye while the other is being examined. Do not press on the covered eye, as the pressure might induce an incorrect examination.

X. Have the pupil begin at the top of the card and read down as far as he can, first with one eye and then with the other.

FACTS TO BE ASCERTAINED.

I. Does the pupil habitually suffer from inflamed lids or eyes?

II. Does the pupil fail to read a majority of the letters in the number XX (20) line of the test types with either eye?

III. Do the eyes and head habitually grow weary and painful after study?

IV. Is the pupil probably "cross-eyed"?

V. Does the pupil complain of earache in either ear?

VI. Does matter (pus) or a foul odor proceed from either ear?

VII. Does the pupil fail to hear an ordinary voice (with either ear) at twenty feet in a quiet room?

VIII. Does the pupil fail to hear the tick of a good-sized watch at three feet with either ear in a quiet room?

IX. Does the pupil fail to breathe properly through either nostril?

X. Is the pupil an habitual "mouth breather"?

ORANGE PUBLIC SCHOOLS.

Medical Inspection Department.

To Parents:

After due consideration, it is believed that your child has some ^{ear} _{eye} disease, for which an ^{ear} _{eye} doctor of recognized standing should be consulted. If you feel unable to consult one at his office, the Orange Memorial Hospital Dispensary will do the work free of charge.

It is earnestly requested that this matter be not neglected, as children with eye and ear disease cannot attain the best results in school.

Respectfully,

_____, *Principal.*

_____, *School.*

This plan of inspection has been in effect in the schools of Orange for the past three years and in South Orange two years. In East Orange practically the same plan is in force, except that the work is all done by one teacher, which no doubt is much better and leads to more uniform results. The Superintendent of Schools in West Orange has become impressed with the value of the plan and assures me he will have it in force next year. The good results accomplished is evident by the large number of children who have come under my observation at the Orange Memorial Hospital, most of whom were much in need of ear and eye treatment.

From a recent letter from Mr. Foster, Superintendent of Schools of South Orange, I quote as follows: "Individual cases could be cited where a great deal of good has been done, making it possible for the student to do far better work and improve his health generally. I have no question as to the value of the work." From a recent letter from Dr. Swingle, former Superintendent of Schools of Orange: "I am of the opinion that much good has been accomplished and I see no reason why every system of schools should not conduct such an examination for the good of the children. It is inexpensive, takes but little school time,

and in all probability has done much good. The scheme, therefore, has received my hearty endorsement."

From page 13 of the Annual Report of the Orange Board of Education for 1904 I take the following: "The results attained in the special eye and ear test, which was ordered by the Board at the opening of the schools in January, were interesting and much practical good has resulted. The teachers made the inspection, as directed in the instructions which they received, and the results were carefully tabulated and are kept on file in the principals' offices. About 1800 pupils were examined and of that number 25 per cent. were found to be defective in either the right or left eye; 12 per cent. were defective in both eyes, and about 150 were advised to consult a physician for either eye or ear trouble. In one case the child's life was undoubtedly saved by the prompt attention the case received. The results have far more than repaid all the labor and expense the test required. The teachers have a more intelligent idea of the situation, and in some cases they were surprised to learn that the child was defective in either sight or hearing, and that they were asking more than could be expected from the child. Parents, in most cases, have coöperated with the schools, and we are certain that much good has been done. Such an examination should be made at the opening of every year's work and incalculable good will result."

In view of the good which can be accomplished by the universal adoption of this plan, I have drawn a suitable resolution asking this Society to endorse the plan, and our President to appoint a committee of three to take steps to secure the passage of some such law as that recently passed by the State of Vermont.

RESOLUTION.

Resolved. That the Medical Society of New Jersey heartily endorse Dr. Allport's plan of inspection of the eyes and ears of school children by school teachers, and that our President appoint a committee of three who shall attempt to secure the passage of an act by our Legislature similar to those recently passed by the States of Vermont and Connecticut.

DISCUSSION.

Dr. Norton L. Wilson, of Elizabeth.—A vast number of children are embarrassed in their education by defects of the eye or ear, and I believe that a great benefit, not only to the children but to society at large and mankind in general, would

be effected if such physical defects could be detected and relieved. I am in favor of the plan as proposed by Dr. Allport, and so enthusiastically championed by Dr. Emerson, as practical and inexpensive.

In my work at the Pingry School for Boys I examined every boy individually for the past six years, going over his heart, lungs, spine, shoulders, eyes, ears and throat. The number of boys varies from 100 to 150. They were all examined in my office and the greatest number examined in one day was six. This I can do in about an hour, or a trifle over ten minutes to each boy, and this only under the most favorable circumstances. In other words it takes from four to five weeks to complete these examinations. In these examinations I determined whether the boy had myopia, hypermetropia or astigmatism, but did not attempt to ascertain the amount of each. I find the average amounts for the six examinations from 1900 to 1905 inclusive were as follows: Myopia, 4.1 per cent.; hypermetropia, 7.1 per cent.; astigmatism, 3.0 per cent. We have in the city of Elizabeth about 8,000 children in the public schools, exclusive of the parochial and private schools. If the same proportion held good in the public schools as I found in the Pingry School we would have 328 myopes, 568 hypermetropes and 312 astigmatic children; and yet I will venture to say not 10 per cent of these defects are corrected, and in view of these facts and those expressed by Dr. Emerson I beg leave to second the resolution offered by Dr. Emerson.

Dr. Edward E. Wori, of Newark.—I am much interested in this question. In fact, we have already taken measures in our city along this line where 44,000 school children are involved. It seems to me though, that before advocating a law to be presented before the next meeting of the Legislature we are overlooking that which already exists, a law which we can make use of. If you will examine the school laws of 1903 you will find that it is stated that the school children should be examined to determine whether or not any physical defect exists and if so that a record should be made of it. Again, it states that where a systematic medical inspection of schools is made, the inspectors shall instruct the teachers in the first signs of communicable disease and measures which tend to promote the health and prevent disease. Now, if we add a new law when the old one exists, which can be made use of, we are not doing right. An examination of school children on the eve of an athletic contest showed that 25 per cent. of them had catarrhal troubles of the nose and throat and it is probable that this estimate is too low; it probably would be more correct to say, 50 per cent. of the children are so afflicted. This condition is followed by anaemia and a badly developed chest. The measure advocated by Dr. Emerson is a good one and should be extended to the entire State of New Jersey.

Dr. Linn Emerson, of Orange.—I agree with what has been said regarding the present law, but I do not think the present law is explicit enough. This plan of inspection I have advocated is not *medical* inspection of the school children, but an inspection by the school teachers; by a non-medical person, and this can be done by the teacher or any intelligent person. Of course this is not meant to conflict with municipalities having suitable school inspection (as in Montclair), but

is merely a start, an examination of the eyes and ears of the school children by the *school teachers*. With the instructions they will receive they can determine the presence of any serious eye or ear troubles; also catarrhal conditions, and the presence of adenoids. This plan is far better than none at all. An examination by the school teachers is better than none at all; an examination done by one teacher is better than by several; examination by a nurse is better than an examination by one teacher or by teachers; an examination by a doctor is better than an examination by a nurse; an examination by an eye and ear specialist is better than an examination by an ordinary physician. This is meant to be merely a start. The law is explicit. In Massachusetts they had a law, a school law, in which it was stated that this "might" be done, but it was not done until later. As now stated by the Massachusetts law, the children "must and shall be" examined each year. The only exceptions to be made, as before said, is where they already have an adequate system of school inspection in force.

OEDEMA OF THE LARYNX: TWO CASES ASSOCIATED WITH ACUTE SEPTIC DISEASE OF THE THROAT.*

By Frank C. Ard, M. D., Plainfield, N. J.

Assistant Surgeon Eye, Ear, Nose and Throat Department, Muhlenberg Hospital, Plainfield.

A case of oedema of the larynx recently came under my observation, and in looking up the literature of the subject, it occurred to me that it might be of interest to this Society. In some remarks following the report of this case and another that I saw several years ago, I have not attempted to give a systematic review of the subject but have merely noted some points that may be interesting in connection with these cases.

H., male, age thirty-two, was first seen in consultation with Dr. Murray on April 14th, at the Muhlenberg Hospital, Plainfield, N. J. He had been under the care of his family physician for about two weeks with an inflammatory affection of the throat, which, beginning as an ordinary tonsillitis, finally extended to the larynx, causing difficulty in breathing. The patient had been drinking freely for a few days. On examination we found the patient breathing with great difficulty, a decided degree of hoarseness present, marked dysphagia, very restless, profuse muco-purulent expectoration, temperature of 100.2, respiration 30, pulse of 112. Appearance of the pharynx normal. Examination of the larynx revealed swollen ventricular bands of reddish color, obscuring the view of the vocal cords, arytenoids

very much swollen, mucous membrane in this region oedematous, and flopping in and out of the cavity of the larynx with the respiratory movements. Epiglottis normal. Externally the tissues of the neck were much swollen, extending nearly to the clavicle. The following day the patient breathed easier, the temperature at its highest point was 99.6, no marked change in the laryngeal condition. The external swelling was much reduced. Examination of the urine revealed albumen, marked trace, granular, hyaline and blood casts. April 16th. Continued profuse expectoration, but no tubercle bacilli present. Swelling on the left side of the neck had almost disappeared, some on the right side remained. Slight lessening of the swelling of the arytenoids. During this period patient was on a fluid diet, calomel and salines had been administered, steam inhalations containing compound tincture of benzoin and adrenalin 1 to 1000 (10 drops every two hours). April 17th, 18th, 19th. Pulse, temperature and respiration practically normal; general improvement in symptoms, only a slight swelling of the neck remained. April 20th. There was a very marked change in his condition; temperature, which had been running normal, reached 103.4, pulse of 136. Patient in a comatose state, unable to swallow. Marked twitching of the arms and legs, almost total suppression of the urine, amounting to only eight ounces in twenty-four hours.

At the beginning of this attack patient had been put on digitalis and nitro-glycerin. At 2 P. M. Dr. Murray and I saw him together, and the pulse being full and bounding, twenty ounces or more of blood were removed from the median basilic vein, and the same quantity of normal saline solution introduced. Dr. Murray opened the vein, and during this procedure his breathing became rapidly worse, so that tracheotomy was required immediately. When the patient was placed on the table prepared for tracheotomy his respiration had ceased, face was without color and eyes rolled up, giving the impression that life had passed away. Dr. Murray did a rapid tracheotomy, incidentally opening up an abscess cavity, apparently burrowing on either side of the larynx extending down beneath the thyroid gland. A large tube was placed in the trachea, and by artificial respiration, natural respiration was soon established, and the patient was put back to bed. The operation was done by infiltration anaesthesia which was hardly necessary, owing to the comatose state of the patient. Owing to the acute nephritis,

* Read at the 120th annual meeting of the Medical Society of New Jersey.

we considered the prognosis very bad, but within twenty-four hours after the tracheotomy the patient was perfectly conscious and rational, and since that time has made a very rapid and satisfactory recovery. Tube was removed about the eighth day, the wound healed satisfactorily, and in two weeks the patient was up and about the wards. The condition of the kidneys rapidly improved and the amount of secretion rose to an average of fifty or sixty ounces per day.

Ten years ago I was called to see a patient suffering from earache. I examined the ear carefully and found it normal. I searched carefully for the cause and finally discovered a tender spot in the floor of the mouth under the tongue, which, when pressed upon, produced pain in the ear. The following day there was a marked increase in the symptoms, and the inflammatory process was much more marked. My patient was a resident of New York, who told me that, as she was visiting here, if her illness was of a serious character, she wished to return home. At this time there were no indications of involvement of the larynx but I advised her that it might prove serious and she returned the following day to New York. I was informed later that her physician had called a surgeon in to open the abscess which had developed, and while ether was being administered an attack of suffocation developed, and an immediate tracheotomy was done in order to save the patient's life. The case was one of Ludwig's angina and the subsequent development of suffocation requiring tracheotomy leaves no doubt that a sudden oedema of the larynx developed while ether was being administered. This view of the case has been confirmed by a letter recently received from Dr. F. W. Murray, surgeon to the New York Hospital, who was called in by the family physician. He states, "The abscess was beneath the tongue; ether was administered and its irritating effect caused the oedema of the glottis to become complete, and I had to resort to a hasty tracheotomy. After tracheotomy, as the patient's condition was critical owing to a heart lesion, I desisted from further operative interference, and on the following day the abscess ruptured into the pharynx and almost choked the patient to death, but the tracheotomy tube saved her." Dr. Murray believes that the proper method of approaching these abscesses under the tongue is by the external route under cocaine anaesthesia.

The occurrence of laryngeal oedema is comparatively rare. Few men have seen a large number of cases. This becomes evident in examining the literature on the subject. Rice, in 1898, published an exhaustive article on the subject, entitled, "Acute Inflammation of the Upper Air Passages Accompanied by Laryngeal Oedema," in which he tabulated an account of forty-one cases, all that could be found in the literature from 1887 to 1898. Semon, in the *Medico-Chirurgical Transactions*, published in 1895, reports fourteen cases of septic inflammation of the throat and neck, in which laryngeal oedema was present in all but one case in his very extensive experience. No doubt many cases occur that are never reported. Some of you may recall cases of suffocation, associated with inflammatory affections of the throat. In looking up this question there is much confusion owing to the different classifications by different authorities. I propose to eliminate from discussion the oedemas associated with chronic disease of the larynx, such as tuberculosis, syphilis, tumors, etc., also those oedemas associated with the different varieties of nephritis, heart and lung disease, etc., where the oedema of the glottis is associated with oedema of other portions of the body. We will consider only oedema associated with acute septic inflammations of the throat and neck. As my personal experience is not large enough to offer you any original views on the subject, I shall quote freely from Semon's Article, Vol. LXXVIII, *Medico-Chirurgical Transactions*; Rice's Article, *New York Medical Journal* (Dec. 3, 1898) on "Acute Inflammatory Conditions of the Upper Air Passages Accompanied by Laryngeal Oedema," and Harmon Smith's article in the *Medical Record* (April 21, 1906), entitled "Laryngeal Oedema."

To simplify matters we will assume that Semon's conclusions are correct—which he states in the following words, "That the various forms of acute septic inflammation of the throat and neck, hitherto considered as so many essentially different diseases, are in reality pathologically identical, that they merely represent degrees varying in virulence of one and the same process, that the question of their primary localization and subsequent development depends, in all probability, upon accidental breaches of the protecting surface through which the pathogenic micro-organisms which cause the subsequent events found an entrance, and that it is absolutely impossible to draw at any point a definite line of demarcation

between the purely local and the more complicated, or between the oedematous and suppurative forms. The milder forms of the disease are represented by the first four cases Semon reports: Case 1. Acute oedematous inflammation of the palate and pharynx; recovery. Case 2. Acute isolated oedematous inflammation of the epiglottis; recovery. Case 3. Acute oedematous inflammation of the posterior wall of the larynx, with slight infiltration of the left side of the neck; recovery. Case 4. Acute oedematous tonsillitis, pharyngitis and epiglottis; recovery.

As examples of the greatest forms are: Case 11. Acute oedematous inflammation of tonsils, pharynx and larynx; double basic pneumonia; death. Case 12. Brawny infiltration of neck; congestion of pharynx; general inflammatory oedema of larynx; left-sided pleurisy and pneumonia; death. Case 13. Acute oedematous inflammation of epiglottis, arytaeno-epiglottic folds and mucous membrane over arytaenoid cartilages; abscess over left arytaenoid cartilage; brawny infiltration of neck; double pleurisy; delirium; attempted suicide; death. Case 14. Brawny induration of neck; follicular tonsillitis; acute inflammatory oedema of epiglottis and left arytaenoid cartilage; deep-seated abscesses in neck; double pleurisy; peritonitis; superficial abscesses; death.

The two cases I have reported are intermediate; more grave than the first four mentioned, milder than the last four. It can be readily seen that the disease in any form warrants extreme care and watchfulness; the mild forms yield to treatment, the intermediate forms, if prompt surgical treatment is given when necessary, may be saved, while in the grave forms the toxic effect of the poison is so profound that we may not hope to save the patient until such time as we are armed with a serum capable of neutralizing the effect of the micro-organisms. In these severe forms the disease may run so short a course as eleven hours, as in one of Semon's cases. It is a matter of regret that a culture was not secured in these two cases, but the emergency was such in each that no opportunity was offered. We may consider the streptococcus, staphylococcus and pneumococcus as the usual agents, but there are a large number of pyogenic organisms and we have not yet a complete knowledge of the subject from a bacteriological point of view. It has been stated by Jordan that the pyogenic organisms are capable of producing all forms of

inflammation, and whether we have serous, fibrinous, croupous, purulent or hemorrhagic inflammation, depends upon the intensity of the process. No age is exempt from acute septic inflammation of the throat and persons in perfect health may be attacked. Prodromal symptoms are present in some cases, manifested by chilliness, slight temperature, headache, sore throat, etc., while in other cases the onset is sudden and severe, with chill, rise of temperature and great prostration.

No dependence can be placed upon temperature as an indication of the severity of the inflammatory process, as in some of the most severe cases the temperature may not be more than one or two degrees above normal. It may register highest at the beginning of the attack, gradually falling; elevation later points to some complication. The pulse is usually weak and easily compressible and ranges from 90 to 130 as a rule. From the location of the disease, difficulty in swallowing would be expected. This varies in degree, at times amounting to absolute inability to swallow. Pain is also always present, hoarseness and difficulty in breathing occur when the larynx is involved. Difficulty in breathing varies according to the amount of stenosis present: when well-marked occasioning distress, not only to the patient but also to anxious friends who are helpless to aid. Moments of relaxation and relief may occur but are usually followed by severe paroxysms that threaten suffocation. When the disease attacks the tonsil first there is nothing to distinguish it from an ordinary tonsillitis. In Case 1 of my own, the physician in attendance reported to me that the appearance was similar to follicular tonsillitis, but progressed to a point where he thought a peritonsillar abscess was forming. While developing in the tonsil its nature may not be evident, but when the posterior wall of the pharynx is attacked the inflammatory reaction is much more marked and with more of an oedematous appearance than in ordinary acute pharyngitis. The tonsil and pharynx are not always the parts first affected; sometimes the initial point of inflammation is in the tissues of the neck, the larynx, or the floor of the mouth between the genio-glossus and the mylo-hyoid muscles; when situated here it is known as Ludwig's angina, although the term is sometimes used to describe various suppurative processes in the neck.

In Case 1, when I first saw him the pharynx and tonsils were normal in appear-

ance. This is rather characteristic of the disease, extension usually taking place below, leaving the parts first affected free from the disease. The inflammatory process may spread to the tissues and glands of the neck, and the term brawny swelling aptly characterizes the board-like feeling on palpation. When the tissues of the neck are affected they are usually very sensitive to pressure. When the larynx is involved, either primarily or from extension of the disease, the epiglottis is usually most frequently involved, next the ary-epiglottic folds and mucous membrane over the arytaenoid cartilages. My first case varies from the usual in that the epiglottis and ary-epiglottic folds were not involved. The swelling of the parts above the vocal cords usually prevents an inspection of them. Sometimes the epiglottis is so enormously swollen as to prevent inspection of any part of the larynx. The oedematous process in the larynx may become purulent, the exudation in the tissues of the neck, if present, may be serous or purulent and go on to abscess formation. Purulent inflammation is a much graver form of the disease, but in some cases the poison is so overwhelming as to cause death by toxæmia before pus is formed. When limited to the neck we may hope for a successful issue, but the disease sometimes spreads rapidly below, and the lungs, pleura, pericardium and abdominal cavity become involved or a meningitis may develop.

Treatment—Purulent foci should be opened as soon as recognized. In the early stages ice applications to the neck are indicated. Abraham, in the discussion of Smith's paper, stated that he considered a 25 per cent. solution of ichthyol of great value and he uses this solution in all cases of septic sore throat. Rupp reported a recovery in a case of acute and severe oedema of the larynx, treated only by ice applications, and tincture ferri chloridi internally. The value of adrenalin in oedema of the larynx, according to French, is undoubted. In a case which he reported where the epiglottis, arytenoid cartilages and ary-epiglottic folds were very oedematous and respiration labored, he applied a 1-5000 solution of adrenalin by means of an applicator with marked improvement and ultimate recovery. Applications were made hourly. He mentions two other cases where the same remedy was used, but oedema returned owing to the too early discontinuance of the remedy. The remedy may be given internally also. Scarification of the oedematous tissue

is of value and is best done with a guarded knife. Lenox Brown recommends hypodermic injections of pilocarpine. Inhalations of steam with benzoin are recommended by some authors. Preparation should always be made for rapid tracheotomy. I would refer those who desire further knowledge of the subject to Semon's classic article which covers the subject fully.

DISCUSSION.

Dr. Norton L. Wilson, of Elizabeth—We all see these cases of severe sore throat without the larynx being affected. Whether there is any specific sore throats which produce oedema of the larynx or not I am unable to say. Oedema of the larynx, in fact all oedemas in any part of the body, are due to the escape of healthy normal serum into the submucous or connective tissue, thus producing swelling in those relaxed portions, as about the epiglottis, or epiglottidean folds. That is why we see in these cases of oedema so much more swelling than elsewhere. Any inflammatory condition surrounding the larynx may be capable of producing oedema of the larynx. Iodide of potassium has been known to produce oedema of the larynx by administering three drachms of a 5 per cent. solution. Influenza has produced oedema of the larynx, and Löri reports oedema of the larynx occurring in connection with malarial cachexia. We all know that oedema of the larynx is frequently due to nephritis, and the doctor mentioned that as one of the causes. Typhoid fever may produce oedema of the larynx by producing ulcers in the mucous membrane; these are also to be found in the intestinal mucosa; this is accompanied by the transudation of serum into the tissues and may produce quite a severe attack of oedema of the larynx. I have seen a case of oedema of the larynx develop in angio-neurotic oedema, but I have never seen any mention of such cases in the text books, although there have been some cases reported in the literature on this subject. This should be added as a cause.

I want to make a plea for tracheotomy in cases of oedema of the larynx. On the 16th of March I had the case of a man, sixty-four years old, with oedema of the larynx. He was sent to the hospital at noon and at 3 o'clock the oedema was punctured with the result that he breathed easier, and he was then placed in bed. He was given inhalations of adrenalin and apparently was made comfortable by it. He was in the hospital under the care of a trained nurse and the house physician was prepared to do a tracheotomy at any time. At 3 o'clock in the morning the house physician was called, but before he could get to the patient he was dead. I now firmly believe that if we had not temporized in the afternoon by simply puncturing the oedema but had done a tracheotomy, that man would have been alive to-day.

So far as adrenalin goes I am satisfied that it is not a safe drug in this disease, nor is any drug safe to rely upon in a disease of this character.

The best site for an urgent tracheotomy is through the crico-thyroid membrane. To hold the opening apart a couple of hair pins bent at the end may be used as retractors.—*Amer. Jour. of Surgery.*

THE TENDENCY OF THE ORGANISM TO LIMIT PULMONARY TUBERCULOSIS.*

By Theodore Senseman, M. D.,
Atlantic City, N. J.

In presenting this subject I am well aware that the time limit will permit me only to touch upon it in a very superficial manner, and yet, I think this phase of the subject of such importance in its relation to our study of the development of the disease, and the application of a treatment to eradicate the process, that it deserves more consideration than, in the past, it has received. That the disease tuberculosis tends towards a spontaneous cure in the large majority of cases is well recognized, but I question if the process by which this spontaneous cure is made possible is equally well understood.

In treating this subject we must take into consideration the parts played by the organism (the body in general) and the micro-organism (the tubercle bacillus). The whole question of this disease is one of war between these two factors and the entire rational treatment consists in supporting the organism in its fight against the micro-organisms and their products—the toxins. We have, therefore, exactly the same proposition as is presented by all the infectious diseases, such as typhoid, pneumonia, diphtheria, etc., the only difference being that the former is of much slower progress and longer in duration, which is due to the fact that the tubercle bacilli are very slightly irritant, while at the same time they are very resistant. By this tendency to limit tuberculosis I therefore mean the tendency of the organism to adapt itself to the toxins, which are elaborated by the bacilli at the point or points of lesion, and which, circulating in the blood, produce the conditions which are recognized as the symptoms of the disease. I would offer in proof of the existence of this tendency the large number of spontaneous recoveries that occur and the reasonable supposition that did it not exist the disease would have long since depopulated the earth.

The disease typhoid fever offers a very interesting illustration of this limiting power on the part of the organism. Here we have the entrance through the digestive tract of the bacillus typhosus which travels down through the stomach and small intestines until it finds lodgment in the follicular struc-

tures of the lower part of the ileum and upper part of the colon which we call Peyer's patches. Gaining lodgment here, the bacillus immediately starts its life work of producing toxins which are taken up and passed along by the general circulation. The local irritation produced by the lodgment and growth of a number of these bacilli is responded to by the organism and in consequence large numbers of leucocytes, playing their role as the body scavengers, are sent to the point of irritation in the attempt to absorb the disease producing germs and so carry them away and destroy them. But while, perhaps, partially successful at first they ultimately fail in this and are themselves destroyed—the disease germ multiplying and manufacturing toxins, ever greater in amount and more virulent, which are taken up by the blood and circulate through the body as free toxins. This continues for a time but there comes a change and it occurs in this manner: The toxins circulating with the blood stimulate certain cells of the organism which, in response to this stimulation, produce an anti-toxin and this anti-toxin or these anti-toxic bodies also circulating with the blood directly neutralize the toxins and render them inactive. Once the organism starts this production of anti-toxins it continues until the amount and strength are far in excess of the toxins and finally this excessive amount circulates in the blood un-neutralized and comes to act directly upon the lesion itself. Now there is all this time a constant emigration of leucocytes to the seat of lesion and these young corpuscles entering the circulation from the bone marrow, where they are mostly manufactured, become more or less accustomed to the toxins and receive a degree of immunity which makes them more effective and resistant than the earlier crops—thus these immunized corpuscles, aided by the anti-toxic bodies, are finally so far in excess of the disease producing germs and their toxins, that they destroy them faster than they can multiply and the patient recovers. Just what part or parts of the organism are concerned in the production of those anti-toxic bodies is, I believe, not definitely known. But whether they are produced solely by the leucocytes, as claimed by Metchnikoff, or whether Ehrlich is correct in his theory that they are produced by other cells aided, perhaps, by the leucocytes, they do exist.

The Widal reaction in the above mentioned disease is found upon this adaptability of the organism, for when, on the fifth or sixth day of the disease, we take the blood

*Read at the 140th annual meeting of the Medical Society of New Jersey

of a patient suffering from typhoid and bring it in contact with the culture of the typhoid bacillus, we immediately have a reaction. The bacilli are killed and the characteristic clumping occurs, showing the action of these anti-toxic bodies. If the blood does not contain these bodies the culture is unaffected and the bacilli continue to grow. This we know often happens even though typhoid really is present, but this can be easily explained on the ground that the stimulation produced by the toxins on the organism has not been sufficient to cause a response. The treatment of disease by antitoxin makes use of this same principle of limitation. In diphtheria, for example, we take the serum of an animal inoculated with the exudates of the diphtheria bacilli and inject it into the body of our patient so that the anti-toxic bodies produced by the organism of the animal will reënforce this same kind of body which the organism of our patient is endeavoring to produce in sufficient quantities. The rationale of the tuberculin treatment is also based upon this fact. Here it is the intention to increase the toxins in the blood so that the organism will receive a greater amount of stimulation and in response will manufacture a greater amount of anti-toxin. In using this treatment we are, however, dealing with a questionable and at times dangerous method, for the trouble in tuberculosis is not the want of stimulation but the inability of the cells of the organism to respond to the stimulation which they are already receiving, and hence we but further weaken these already too weak body cells and simply add to the sum total of the toxins in the blood.

Koch has shown the presence of these anti-toxic bodies and this tendency towards disease limitation by injecting into the body of an animal some distance from an already existing localized tubercular process a virulent culture of the tubercle bacillus. He found that while at the seat of injection there was set up a local irritation which lasted several days, no development of the disease proper—no tubercular process followed, showing that there was something in the blood of the animal which enabled it to entirely destroy this second infection. In other words there was in the blood this anti-toxin, which was present as a result of the stimulation on the organism by the toxins of the original infection—the organism had adapted itself to the tubercular toxins. And so when we come to consider pulmonary tuberculosis we have exactly the same state of affairs as is presented by typhoid fever.

Although we are constantly breathing an atmosphere more or less loaded with tubercle bacilli, nature is constantly protecting us against invasion. In health we find that these bacilli are for the most part destroyed by the mucous membranes of the nose, throat and pharynx, and few if any find access to the pulmonary tissues. When they do find their way to the lungs they are soon overwhelmed and no further result is noticed. In proof of this we note the large number of cases that, after death, show the presence or remains of a tubercular infection in the lungs which during life gave no signs and was never suspected—all because the cells of the organism, being in a healthy state, were able to adapt themselves to the toxins and, responding to the stimulation, produced the anti-toxic bodies in amounts far greater and much faster than the bacilli could multiply and produce their toxins.

Thus we see that the leucocytes alone are totally unable to destroy the germs—the lung tissue cannot successfully cope with the lesion and so the entire organism is called upon to form the army of defense, and just as the organism responds to this call will the result be recovery or death, and just as we recognize and make use of this fact will we succeed or fail in our treatment of the disease. Now, if from any cause the body cells are weakened and cannot fully respond to the toxin stimulation, we have another state of affairs. Here we note the slow but sure development of the tubercle from which emanates the toxins which, acting upon the body in general, produce the various manifestations of the disease. The factor which seems to control the result of the process—whether spontaneous recovery or a continuance of the disease, seems to be the condition of metabolism. So long as the metabolic equilibrium is maintained, the disease cannot make itself felt to any extent, but once this equilibrium is disturbed and we have set up a destructive metabolism or katabolism we find the disease making inroads and soon its presence is plainly demonstrable. In proof of this we note that in nearly all of our patients who develop pulmonary tuberculosis in which the process extends sufficiently to permit of its being recognized, we will find on close examination into the history of the case that digestive disturbances have been present to a greater or less extent and that this disturbance has been noted long before any lung symptoms. Coupled with this there may be present as a result of this katabolic process a gradual but constant and appar-

antly unexplainable loss of weight with the consequent increasing weakness. As this destructive metabolism becomes more marked we have plainer evidences of the increasing disease until there is established a vicious circle where one condition increases and aggravates the other. The symptoms of the disease very plainly show this metabolic change, for we note that in the early morning hours after the body cells have received, during the hours of rest and sleep, a greater amount of nourishment they are able to meet the toxins and neutralize them and consequently we have the normal temperature and pulse rate. Later in the day, however, when the ordinary exertion which accompanies the waking hours adds a tax upon them, we find that they are not receiving sufficient nourishment to withstand this extra strain and hence the toxins are in excess and with this excess and as a result of it comes the elevated temperature, rapid pulse, etc. So long as the body cells have simply the toxins to meet they receive sufficient nourishment to successfully cope, for a time at least, with the disease, but when physical exertion is added to this burden we find them embarrassed. Through this fact comes the benefit which is derived from the rest treatment when employed in this disease. But while considering this power of adaptability on the part of the organism we must not lose sight of the fact that the tubercle bacilli, in common with most disease producing germs, also possess this same power, although to a much less degree. If this were not the case we would find that these germs, which are finally destroyed, would be unable to grow at all and there would be no disease process in these cases. That they possess this power to a much less degree than do the body cells is evidenced by the fact that tuberculosis tends for the most part toward recovery, by the large number of cases in which we have a spontaneous recovery where there never was present during life any appreciable evidences of the disease and where, after death, the autopsy shows unmistakable signs of the former lesion in the lung tissue.

We must also bear in mind that there may be present the toxins of the streptococci and staphylococci, for in tuberculosis we have presented a mixed infection in most cases and always where the daily variation in temperature is decidedly marked. The presence of this mixed infection explains, perhaps, the benefit which has been claimed for the use of the diphtheria anti-toxin in this disease, the beneficial action being due to the

so-called "immune bodies" which are found in the anti-diphtheritic serum. Where we consider this tendency of the organism to limit tuberculosis in its relation to the treatment we find that the entire rational treatment is based on this one fact. Our one aim is to convert this condition of katabolism to one of constructive metabolism or anabolism, with the idea that in so doing we will sustain and strengthen the cells of the organism; for, as has been pointed out, it is the organism that accomplishes the cure. We have no specific, no panacea with which to combat the bacilli and their toxins and all our treatment can but help the patient to help himself. Hence we have adopted, and with good results, forced feeding which, however, if improperly applied, is capable of much more harm than good. The habit of giving the patient three large meals a day of solid food and forcing in eggs and milk before, during and after these meals, is I believe a bad one. Our consumptive patients should not be instructed to follow the plan of the man who said "he ate until it hurt and then stopped while the pain lasted. No good digestion can stand this over burdening for any length of time without deleterious effects resulting, and it is not reasonable to suppose that a digestion already showing a tendency towards weakness can do more than when in a healthy condition. While the patient should be fed to the utmost limits of his digestive ability, we must see that the food is being assimilated. I believe the most satisfactory plan is to have the patient make two of the three meals on raw eggs and milk entirely and make these meals extend over some time so that more can be taken and feeding between meals will not be necessary, then allow him one meal of solid food, plain but nutritious.

This will give trouble at first, for very few consumptives there are who, on receiving this advice, will not say that they cannot take eggs and milk, but if firmness and determination are used it will usually be found that this "cannot" really means "will not." Of course occasionally we will find patients who will not do well on this regime, who really cannot take this diet without more distress than good resulting, and then we must do the best we can. These patients constitute fortunately a small percentage of our cases and if we will follow this system we will accomplish a great deal for most of our tubercular patients. This question of increasing the amount of fat ingested by our patient often gets many of us into

trouble. Where it is possible to give a fair amount of good fresh milk, we will thereby meet this question of fatty food and moreover we will be giving the fat in the most easily digestible form. Our patients should early be educated to a proper appreciation of the beneficial results derived from the daily bath. It has been my experience that, where well borne, the morning sponge with tepid, or better cold, water gives the best results. The cold bath, however, should never be taken while the body is cold, at such times it is better to precede the cold sponge with a hot one so that the body may be warm, for in this way the cold sponge following produces a greater shock and a quicker reaction. We must, however, study the individual and apply that form of bathing which produces the best results and from which our patient reacts quickest. Some form of daily bathing, however, should be insisted upon.

Our tubercular patients should average from ten to twelve hours out of the twenty-four in bed. This I believe to be a very important part of our treatment, for while the body is resting the cells of the organism are receiving their full quota of nourishment. When the temperature exceeds 100 degrees absolute rest should be insisted upon, but in the other cases exercise that does not produce a rise of temperature or an undue increase in the number of pulse beats is of decided benefit. Here again we must study the individual and insist that the amount and kind of exercise shall be governed by its effect upon the temperature and pulse beat. That portion of the treatment which presents the most difficulties to the physician is connected with the procuring for the patient of an abundance of fresh, pure air. The tubercular individual should never breathe twice the same air, but it is very difficult and often impossible to persuade him that draughts do not produce colds and that a low temperature and a moist atmosphere present no contra-indications to his going and remaining for long hours out of doors. It is pure air we are after and it matters very little whether that air be dry or moist, of high or low temperature, whether it be the air at the sea level or on the mountain top so long as it is pure.

The question of the beneficial effect of a change of climate seems still a mooted one. A temporary and at times permanent change of residence is often attended with marked beneficial results, but I do not believe that this benefit is due to any specific virtue in the climate itself, for in my opinion, there

is no climate for which any specific action can be justly claimed. There is this to be said, however, viz.: Experience has taught us that in certain portions of the Southwest, more especially New Mexico, the patient can remain out of doors with considerably less discomfort than here in the East: there the inclination is to stay out, while here the inclination, during our longer and more harsh winters, is to seek comfort in the higher temperature of the house. In this, together with the fact that the altitudinous regions naturally demand an increased lung expansion, lies the only benefit derived, except, perhaps, that our patients away from business and home environment give their entire attention to getting well, while if at home they will most surely compromise the matter and divide their attention between business and home cares and the means of cure, giving the larger share to the former.

Just a word in closing as to drugs in this disease. The method of treatment founded upon the idea that the words consumption, creasote, cod-liver oil and whiskey are indissolubly associated should have long since been relegated to its proper place among ancient and harmful procedures. But unfortunately there are still many who persist in following this course, and the diagnosis made at once proceed to pour these things down the unfortunate patient's throat until he fairly reeks with creasote, emits a breath that does not belong outside of a bar-room and until he sweats cod-liver oil from every pore of his body. I question, gentlemen, if the digestive apparatus of a healthy and vigorous hog could withstand such abuse. I have seen many patients whose only chance of a recovery has been sacrificed upon this creasote—cod-liver oil—whiskey altar, who really died of starvation where the lung lesion gave undoubted evidences of the possibility of a cure or at least of an arrested condition. This same thing is true of such drugs as are included in the iodine group, as for instance, iodoform, and if we will acknowledge the importance of a good digestion in the treatment of tuberculosis (and he who does not fully appreciate this importance knows very little about the subject) then I am at a loss to understand through what process of reasoning we can reconcile this belief with the administration of these drugs. It has been advised that certain preparations of iodine in the form of an unguent be applied locally to the skin. This procedure may do good but it seems to me a long cry from the skin of the abdomen to the lesion of the lung apex. I am well

aware that innumerable claims have been made as to the beneficial action of these drugs upon the lesion, a temporary benefit may appear to follow their administration at first, but in the end they will surely do harm and it is not this temporary and fleeting good that we are after but the ultimate and lasting good. Drugs that aid digestion and drugs for the relief of symptoms which are causing, through interference with rest and their debilitating effect, more harm than the drugs themselves, have a place in our treatment. Strychnia, morphine, the bromides, and an occasional physiological dose of whiskey are often indicated, but anything which tends to retard or inhibit the accomplishment of the above mentioned ultimate good, any treatment which depresses the organism rather than strengthens it, any treatment which tends to further disturb the metabolic equilibrium, is, to my way of thinking, infinitely worse than no treatment at all.

CONGENITAL BODY-CLEFT WITH EXTRUSION OF HEART AND STOMACH.

CASE OF CELOSOMA.

By Frank W. Pinneo, Reporter, Essex County.

This case of a monster is reported by Dr. Carl Herman Wintsch for simultaneous publication in the *Journal of the Medical Society of New Jersey* and *Annals of Surgery*.* He says:

"April 15th, 1906, I was called to see Mrs. H., age 38, and delivered her of a living male child, normal in every respect excepting for a complete protrusion of the heart, stomach and spleen.

"Family History. Parents of the father are living and healthy. He is 35 years of age, and is a tailor by trade. He is the third child of fourteen healthy children born unto his parents. The mother's father died of apoplexy at the age of 58. Her mother is still living and healthy and gave birth to seven healthy children. This is the fourth child born unto Mrs. H., all healthy and living excepting one; ages of children 8½, 7, 4½ years. One year and a half ago the 7-year-old child, a male, was run over by a heavy truck, crushing in the entire chest:

*It appears in *Annals of Surgery*, August, 1906. The pressure of our society transactions has prevented its earlier publication here.

he died twenty minutes after the accident, in his mother's lap on the way to the hospital. The mother works hard every day, helping her husband in the tailor shop, besides doing her own housework. During the pregnancy of this child the mother did not feel as well as she did when carrying her other children. She felt miserable and tired, and felt more life than with the rest of her children. During her sixth month of gestation she stumbled over a board in the yard, and fell flat on her abdomen, but felt no ill effects from the fall. She says she had an enormous appetite and that the abdomen was much larger in circumference than with her other children. Labor began at 2 P. M., on April 14; pains became severe about 7 P. M., and child was born at 2 A. M., April 15th. The child was born before I arrived: the labor seemed perfectly normal, excepting a small hemorrhage just before the birth of the child. The child weighed 7 pounds and measured 19 inches in length. Respiration was 30, pulse 120-130, temperature 97.8. It defecated and urinated normally. It became very cyanotic at times, which was aggravated when pressing upon the heart with the hand. The child lived two days and three hours and was fed per mouth with water and milk from breast of mother, which it retained. Just before death the child vomited a greenish fluid and bled from its mouth. The heart was moistened every 15 minutes by a saline solution 99° F., applied to gauze covering the heart. The heart was entirely on the outside of the body, covered by the pericardium. The systole and diastole were distinctly noticeable. The stomach and spleen were covered by the peritoneum."

According to Aristotle (400 B.C.) "Monsters are not contrary to Nature, but to the most usual course of Nature." This we may take to mean that though they are unnatural products of Nature, they yet have natural causes, and it stimulates our study of not only the specimen itself, but also the antinatal environment with all its forces and life processes. What was the cause of the perversion of forces from which so extraordinary a form naturally resulted? A classification of monsters cannot be perfectly satisfactory, for each case is peculiar to itself, and aberrant in particulars perhaps none other has exactly followed. According to the groupings of Geoffroy Saint-Hilaire (1772), whose work in natural history made him an authority on teratology and "the influence of surrounding conditions in modifying animal forms," we can

best call this case one of celosma with median fissure of both abdomen and thorax and evagination of both abdominal and thoracic organs. The body wall is entirely absent from just below the sternal notch of the manubrium to about a centimeter above the umbilicus and for a width of about eight cm. at the widest part. The ribs are entirely normal on both sides close up to this fissure, and the foetus entirely normal in every respect, without supernumerary parts or marks of arrested development, and of full size.

In order to preserve the specimen intact,

body wall to close is the umbilical opening, and this takes place by the tenth week when all the alimentary canal is found within the embryo and the opening closed, but for the cord. In this case the umbilicus is closed, no hernia there, and a bridge of normal skin separates it from the fissure above. This is clearly seen in figure 2, a photograph taken during life, and would have been even better in figure 1 if the cord did not lie upon it.

Intra-uterine life is embryonal from impregnation up to the end of the sixth week and foetal from then until birth. The em-



FIG. 1.—CONGENITAL BODY-EXTENSION OF HEART AND STOMACH;
FRONT VIEW.

it has not been dissected and hence we lack some very interesting information about structure; notably, impairment of heart covering of the extruded viscera is lacking in ectoderm, mesoderm or entoderm (probably in at least one), the relation of the organs (probably heart and stomach are covered by their respective serous membranes and separated by a diaphragm normal except at the fissure) and, particularly the relation of the umbilical structures to the fissure. On the last hinges the question of ar-walls and chambers (probable), whether the rested development, for the last part of the

bryonal period is characterized by organogenesis, while the foetal is characterized by growth of the parts already formed, no new organs appearing. Therefore, in the study of ante-natal pathology, we learn at the outset that deformities due to non-development of a part or organ originated during the embryonal period, for afterward, however normally the embryo may *grow* a missing part is not supplied. In like manner a dwarfed foetus or part may have been duly formed but simply failed to grow, due to some fault arising in the foetal period. This view simplifies the problems of ante-natal

pathology, great as they are, in the matter of time. How about cause? Ballantyne draws emphatic attention to the environment throughout, and says: "Morbid causes in foetal life act chiefly upon the foetus through the placenta; so probably morbid causes in embryonic life act chiefly through the amnion." As the placenta constitutes in foetal life the chief factor in environment, being the only channel of nutrition, and, before it is formed, the amnion is the chief factor, "Disturbances in function," he says, "or diseases arise through the placenta, disturbances in construction through the amnion." This has been proved experimental-

another child, can have no importance, unless we refer it to the pre-existent, or, better, germinal, period of the organism, a realm we cannot claim to have explored with any knowledge. Two assertions can be made. 1. An impression on the mind of a pregnant woman can not be the definite cause of a defect in her offspring, however similar the defect may be to the thing producing the impression. It is a coincidence. 2. A mother's mental state during gestation does have a pronounced influence on the child's development. It is a question of nutrition. Outside causes may be primary on the mother but secondary only on the child.



FIG. 2.—CONGENITAL BODY-EXTENSION OF HEART AND STOMACH; LATERAL VIEW.

ly in the chick embryo irregular development of amnion being a constant factor in the artificial production of monsters. Though there may not be amniotic adhesions found at birth, pressure only at the formative time would explain the deformity, or adhesions may have been absorbed.

On maternal impressions, a subject which has received of late some new attention, this case throws some light (by exclusion). When she fell, in her sixth month, the embryonic stage had long since passed and formation of parts been determined, hence this affords no explanation. The other feelings mentioned during gestation have no bearing. An accident, $1\frac{1}{2}$ years before, to

This, then, is an interesting and unusual case in ante-natal pathology showing normal development except for a very extensive body cleft with eventration, all due to disease of the amnion (adhesion or pressure) early in the pregnancy.

The excellent photographs were taken by Mr. W. F. Cone while the heart was beating violently, and the skiagraph by Dr. C. F. Baker, after death.

Do not be too hasty in making a diagnosis of intercostal neuralgia. With the exception of pulmonary and pleural conditions, ulcer of the stomach simulates intercostal neuralgia more frequently than any other lesion.—*Amer. Jour. of Surgery.*

THE JOURNAL

OF THE

Medical Society of New Jersey.

OCTOBER, 1906.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any one failing to get the paper promptly will confer a favor upon the Publication Committee by notifying them of the fact.

All communications relating to the JOURNAL should be addressed to the Committee on Publication.

TO THE AUTHORS OF SCIENTIFIC PAPERS AND OTHER CONTRIBUTORS.

We give the following prominent place, in the editorial columns of the *Journal*, as fully expressing the views of the editor, and also of the committee on publication:

To Writers of Scientific Papers: *The Deutsche med. Wochst* remarks in a recent issue that many articles sent in for publication of late have been full of mistakes, especially noticeable in dictated typewritten copy. It adds that the editorial staff can not be expected to rewrite the article to correct the numerous errors, and the composing room cannot stand the expense of having the corrections made on the proofs. Consequently in future such Ms. will be returned to their authors for correction or the expense of having the corrections made by the JOURNAL will be charged to the authors. A charge will also be made for extensive alterations in the text when the proof is sent to the author for correction. The *British Medical Journal* quotes this manifesto with approval, saying "it would save much loss of time and needless expense and vexation of spirit to all concerned if writers who confer on us the privilege of publishing their writings would in the first instance send them clothed and in their right mind, instead of swarming with misspelling of names, wrongly numbered illustrations, spaces for dates and figures left blank—as frequently happens, to say nothing of mere repetitions and contradictions, obscurity, etc."—*Journal Amer. Med. Ass'n.*, Aug. 4, 1906.

The August issue of our *Journal* was delayed some days in consequence of exten-

sive changes and additions made in the proofs by an author. The rules of our committee are substantially those set forth in the article above quoted. The editor is willing to save the authors inconvenience and expense when possible, but it requires more time and thought than they are aware of, and more than the editor can sometimes give to make plain words that are indistinctly written and to correct the faulty expressions, etc., in hastily written papers, some of which should be re-written before they are placed in the hands of the typesetter. *The prompt return of proof sent to authors of papers is especially urged.* It should be addressed to the editor, P. O. Box 83, New Brunswick, N. J. If not returned in time the matter, according to the committee's rules, will appear in the JOURNAL as printed in the proof-sheets, with typographical errors only corrected.

THE PRIZE ESSAY.

We call the attention of the members of our county societies to the announcement, in another column, of the Prize Essay Committee and ask: shall we not have several compete for the prize this year? The subject, "Pneumonia: its Etiology, Symptoms, Pathology and Treatment," is most timely. The deaths from this disease in New Jersey for the year ending December 31, 1903, were 2,628 (207 more than the preceding year, or 8.26 per cent. of the total deaths from all causes. In 1904 there were 3,486 deaths, or 9.88 per cent. of total deaths from all causes, and in 1905 there were 2,764 deaths, or 8.16 per cent. of total deaths. Surely, then, this subject is an intensely practical and important one which should receive our closest study. The credit of the profession, the good of the State and the highest interests of humanity demand it, and the marked success of the profession in its investigations of other diseases that have resulted in their more scientific treatment, their limitation or control will doubtless attend their effort in their study of pneumonia and win new laurels for the profession.

The society during its entire history of 140 years has sought to stimulate scientific investigation in various ways, the first record we have of its effort to do so by offering prizes was in 1826 when, at the annual meeting an annual prize of \$25 was offered and action postponed. In 1828 the editor of the *Medical Record* offered to the society \$50 for a prize essay, the society to choose the subject and award the prize. It was accepted and the subject chosen was "The prophylactic power of kinepox; the nature of the varioloid; under what circumstances it may be communicated; whether it is a species of a milder form of variola, and whether it can be communicated to the same system more than once." In 1841 it was resolved that a sum not exceeding five dollars be appropriated annually for the purchase of a book (to be selected by the successful competitor) as a prize for the best essay on any medical or philosophical subject, written by a member of the State or district societies. In 1846 it was suggested that a prize of \$100 be offered for the best essay on syphilis, to be paid in money or in a gold medal of that value; action was postponed two years and it was then referred to the "National Association" for their consideration. We find no further record of effort to stimulate our members in this competitive field until 1882, when, at the annual meeting, the Fellows of the society offered a standing prize, to be awarded annually, of \$100 for the best essay on some medical or philosophical subject, the amount to be paid pro rata by the Fellows living at the time of the award. The committee of award consisted of the retiring president, as chairman, one member selected by the Fellows and one elected by the society annually. This continued until the annual meeting in 1904, when the society resolved, on the recommendation of the Board of Trustees, that the prize of \$100 should be offered annually by the society, the president to appoint the prize essay committee annually.

We find no record of the award of a prize under any of the early offers, or until the Fellows of our society offered the \$100 an-

nual prize in 1882, and indeed that offer seems to have failed for five years to induce any member to enter the field of competition. Since then four prizes have been awarded and two have received "honorable mention," as follows:

In 1887 the first prize was awarded to Dr. Joseph W. Stickler, of Orange, for his essay on "Climatology and Diseases of Essex County." In 1897 two essays were received. To Dr. George Bayles, of Orange, was awarded the prize of \$100 for his essay on "The Value of Antitoxin as a Remedial Agent and as a Protection against Diphtheria," and to Dr. Floy McEwen, of Newark, was given "honorable mention" for his essay. In 1898 the prize of \$100 was awarded to Dr. Frederick R. Bailey, of Elizabeth, for an essay on "The Histology and Pathology of the Central Nervous System." In 1900 two essays were presented. To Dr. Frederick R. Bailey, of Elizabeth, was awarded the prize of \$100 for an essay on "Hydrophobia: with Some Experimental Researches on its Pathology," and "honorable mention" was given to Dr. Alonzo I. Hunt, of Hamilton Square, for his essay on "Hydrophobia."

In 1895, and once since, essays were presented but not meeting the specified conditions under which prizes would be awarded, no prize was awarded.

Why there have not been more competitors we know not. Certainly it has not been because the medical men of New Jersey have not had the ability and the courage to attempt the task; for during all the years of the past, and especially during recent years of marked advance in the progress of medical science, there have been many of our members who have presented valuable papers that have evinced careful study, original thought and conveyed valuable information, and which would have been deemed worthy of the prize had their authors contended for them. We note, that of the competitors, for these prizes, all came from three county societies, and all, except one from the central, were from the northern part of the State. Shall we not this year have some of our able practitioners from the southern section enter the field with those of the upper portion of our State?

OUR SOCIETY AND LEGISLATION.

At the eighty-ninth annual meeting of the Medical Society of New Jersey, held in Trenton, January 23, 1855, an able address was delivered by the President, Dr. Alfred B. Dayton, on "The Past and Present History of the Society, with special reference to Legislative Enactments." It was so forceful and opportune that the Legislature, then in session, consented to the use of the State House for its re-delivery on the following evening before the members of the Legislature, the Medical Society and the public. We shall probably have something to say in the November issue of the JOURNAL on our Society's past record in reference to legislation and our present duty in sustaining our excellent Committee on Legislation, which served us and the public so faithfully and efficiently last year; we shall also hope to hear from its chairman, Dr. L. M. Halsey, and shall insert extracts from Dr. Dayton's address, for his words are as true to-day as when uttered more than half a century ago. We cannot do better at present, as preliminary to further consideration of the subject, than to quote the concluding remarks of Dr. Dayton's address as follows:

"Our motives may be impugned—we may be accused of acting from selfishness or sordidness. Permit me to say that we have no more fear of the triumph or success of empiricism, in any of its forms, than we have of falsehood triumphing over truth. Yet there may be those, incapable themselves of other emotions, who cannot appreciate disinterestedness, or separate self-interest from earnest action. We claim to act from higher and loftier sentiments, no-wise akin to base incentives. The honor and dignity of the profession we cherish, the advancement of our science in all that is useful, we ardently desire. Independent of these feelings as physicians, we believe the honor and dignity of the profession, and the improvement of the science, essential to life and health. That legislation can materially affect the business of those now engaged in the duties of their calling is preposterous; the business of such is comparatively beyond its reach. But to the future we look. We are anxious that our children, and your children, and their chil-

dren's children, may have the benefit and counsel of an educated, an intelligent medical corps; we are desirous that that science which has been maturing for centuries—that that art which has been, slowly perhaps, but surely progressing—shall not be arrested in its onward and upward tendency, by injudicious legislation or a blind adherence to some theory or hypothesis void of good fruit. We come not before you, gentlemen, as supplicants for personal or professional favor; we ask nothing at your hands that will not subserve the interests of your constituents and the world. Let this be accomplished, and you will fulfill the wishes of the people, the Medical Society, and the profession. In conclusion, I would present the thanks of the Society and my own, to the audience for their kind attention, and add one word to my medical brethren. We have a duty to perform, independent of others. Our profession, meanly pursued, sinks beneath a mechanic art; but prosecuted in a liberal spirit, with an eye steady to every light which science sheds upon our path, it is a noble calling, calculated to enlarge the intellect and enrich the heart. Let us remember this; and whatever others may do or not do—whether the law be with us or against us—let us in all time be true to the public and just to ourselves."

MEDICAL EXAMINERS' FEES.

We heartily endorse the action of our State Medical Society in reference to the fees of medical examiners of life insurance companies and we call attention to an editorial in the *Texas State Journal of Medicine* on "The Graded Fee Scheme," which will be found on another page of this JOURNAL. There are several points in this controversy that need to be thoroughly explained, and we are entitled to straightforward, plain statements from the companies rather than specious, misleading arguments. Why the argument of the necessity for the reduction of medical examiners' fees because the New York State law requires it? The fact is that most of these reductions were made long before the companies thought of any such law. The Equitable some years ago made a similar reduction, when there came up to the company such a volume of protests and so

many resignations that they were compelled to restore the \$5 rate. Again, why are the medical examiners discriminated against in this spasm of reduction for popular effect? The officers receive very large salaries not only but their position gives them opportunities (which we will take for granted are legitimate since the late investigation) to make in some cases even more than their salaries. Then the agents get at least forty per cent. of the first year's premiums and most companies give them five per cent. of premiums annually thereafter. If the premium amounts to \$30 per year on \$1,000 policies they receive \$12 the first year and \$1.50 annually thereafter. On \$2,000 policies \$24 the first year and \$3 thereafter; on \$5,000 policies \$60 the first year and \$7.50 thereafter. But the premium sometimes is \$50 on the \$1,000 when the agent gets on these premiums respectively \$20, \$40 and \$100 the first year and \$2.50, \$5.00 and \$12.50 yearly thereafter. The medical examiner receives on the \$1,000 and \$2,000 policies \$3.00 once for his care and critical judgment in estimating the risk. It pays the agent well when he gets a \$1,000 policy. If he gets a \$5,000 policy at \$30 premium per \$1,000 he receives \$60 the first year and thereafter \$7.50 per year; now let the \$55 more than the examiner receives be given him the first year for his work in securing the applicant, why should he be paid \$2.50 more every year thereafter than the examiner receives once. The circular sent out by the company referred to says: "The medical examiner is not called upon to perform work that requires an unusual or special training": does the insurance agent require an unusual or special training to merit that \$7.50 annually? But, says the circular, "it is necessary for him to live in order that life insurance may be written," the argument then is that he cannot live without these amounts are paid him; how then have the agents survived who have heretofore been able to offer forty per cent. to sixty per cent. of the first year's premiums paid by the insured for the sake of the revivals?

Again the company cannot afford it! We will not at present argue that point further than to say that if the companies could afford it under the old order of things—prior to the recent investigations (which revealed the facts of enormous salaries, expensive dinners and prizes and more questionable expenditures) and after spending vast sums for advertising, still added each year large amounts to the already enormous surplus, will anyone believe that, under the better—more business-like management which eliminates enormous, unjustifiable expenditure of the company's funds, it cannot afford to pay liberally to that branch of the service that secures the greatest protection to the company and makes it a reliable and safe company for the insurer? To their honor and commendation be it said that several companies like the *Ætna* and *Mutual Benefit of Newark*, believe they can afford to pay for that which is for the maintenance of their high standing and their insurers' protection. We recommend no company that is not careful in selecting the most competent and thoroughly conscientious examiners and we believe such men should be paid for examinations not less than \$5.00 for \$1,000 and \$2,000 policies, and, if a graded fee system is adopted, the fees should be \$7.50 for \$3,000, \$10 for \$5,000 and \$20 for \$10,000 policies. Such compensation would be about equivalent to a salary of \$5,000 to a Medical Director.

We desire to enter a protest against the closing paragraph of a circular which comes from the medical department of one of our insurance companies that sounds very much like a threat. "If the physicians of the country should decide to form a combination to compel the payment of a flat fee of \$5.00, the companies will certainly be confronted with the problem of either being compelled to unite in the employment of salaried medical examiners—one examiner for each place—or to devise some plan of writing life insurance under which medical examinations can be done away with." Is this worthy a great company which before

the recent investigations enjoyed the world's confidence? Let us have arguments rather than threats; it is a weak cause that needs the latter and we submit it is not in keeping with the ethical spirit and dignity of the medical profession. The first alternative suggested above might be feasible if a salary is paid somewhat approaching that of a medical director, or the company can find a man who has little else to do and is willing to enlarge his line of charity to help a company enlarge its surplus. As to the second alternative—doing away with medical examinations, it would need little argument to prove to prospective insurers that such a company was unworthy of public confidence as it would offer utterly unreliable and unsafe insurance.

THE GRADED FEE SCHEME.

We copy the following from the *Texas State Journal of Medicine*:

The man who first proposed to mask a frank reduction of examiners' compensation by denominating it a "graded fee" is now doubtless pensioned by the insurance companies, or should be. Concerning this, the *Equitable Life* writes us:

"Eighty-five per cent of the total business done in the United States in 1904—the last year before the insurance investigation began—was done by companies which have now adopted some sort of graded fee schedule, and only 15 per cent. of the old line business by companies now operating under a flat fee. It is true, as we believe, that most of the remaining old line companies will soon find it necessary to adopt a graded fee schedule; and if the physicians of the country should decide to form a combination to compel the payment of a flat fee of \$5.00, the companies will certainly be confronted with the problem of either being compelled to unite in the employment of salaried medical examiners—one examiner for each place—or to devise some plan of writing life insurance under which medical examinations can be done away with."

The medical profession has never been offered a graded fee. They have been reduced on 90 per cent. of the policies according to the companies' own estimates and increased \$2 on the other 10 per cent. A justly graded fee would favor the physician too much to expect one ever to be proposed. *These life insurance companies stand charged with juggling with terms, calling a frank reduction a "graded fee;" and with reducing examiners' fees, and justifying the same by pleas of necessary economy, when the very fees adopted prove that such re-*

duction is unnecessary. Here is the proof: the companies concede they can afford to pay \$3 for examinations on \$1,000 policies. Then they can afford to pay \$6 on a \$2,000 policy, \$9 on a \$3,000 policy, \$12 on a \$4,000 policy and \$15 on a \$5,000 policy. Furthermore, the companies are glad to do this very thing (when they have to). A physician receives \$5 for examining a \$5,000 applicant, but the company is ever ready to pay the examiner five \$3 fees if the same insurance be taken at brief intervals in \$1,000 policies. This is a positive demonstration that the companies are able to pay a just and consistent graded fee that would average far more to the practitioner than the flat fee of \$5. The public are paying exactly the same premiums as before; the companies were solvent then as now. Where is the saving? Only in bigger dividends, and the companies still manipulate these profits. *We challenge the life insurance companies of America to disprove this position, or forfeit their right to any consideration of fair-dealing at the hands of the medical profession of America.*

We believe the position taken by Dr. E. L. B. Godfrey, in a communication which will be found on another page, is eminently wise and proper—that the medical men suggested by our Board of Trustees (in accordance with a resolution adopted at the last annual meeting of the State society) to the Governor for appointment on the State Board of Medical Examiners of New Jersey should be men who possess substantially the educational requirements that *the statute exacts* of candidates for the medical license of our State. We have no doubt whatever that our Trustees will exercise due care in the selection of medical men whom they will suggest to the Governor for appointment on any of the State boards on which medical men are to be appointed, whenever it shall be the pleasure of the Governor to receive such suggestions. The highest interests of the State, through the greatest efficiency of these boards, will be their desire and aim.

As the *Journal* goes to press the news comes of the death of Dr. B. M. Skinner, of Belleville, age 71 years. The doctor was one of the Society's most able and active members.

The editor very earnestly requests the Secretaries of the County Societies to forward *promptly* reports of the meetings of their respective societies; also prompt notification of deaths of members with brief obituary notes and any other information of special interest to the profession. We have indirectly heard that several meetings have been held of which no accounts have been forwarded to the JOURNAL. Please let us hear *from you Doctor-Secretary*. Your Society's work is of interest to the profession outside of your county, and the fact that it is reported in the JOURNAL will tend to increase the interest of your members in your meetings. That will help us to do what we desire—to give you a better JOURNAL.

Review of 1,500 Operations on the Gall Bladder and Bile Passages.—DR. WILLIAM J. MAYO, Rochester, Minn., in an address before the American Surgical Association, May, 1906, said the mortality in 1,500 operations was 4.4 per cent. In the last series of 500 cases it was 3.2 per cent. Every patient dying in the hospital, without regard to time or cause of death, is counted as an operative mortality. Of operations for uncomplicated gall-stone disease, the mortality, one-third of 1 per cent., was due to accidental causes. Complications the result of delay caused more than nine-tenths of the death rate; 95 per cent. of all complications occur in patients who have had marked evidences of gallstone disease and ample period of good health for safe operation. Of 845 cholecystostomies, the mortality was 2.13 per cent. In the last series of 500 cases it was 1.47 per cent. Of 319 cholecystectomies, the mortality was 3.13 per cent. In the last series of 500 it was 1.62 per cent. The operation is indicated in all cases in which the gallbladder has lost its function, especially in cystic duct obstructions and for malignant disease. It is a slightly more serious operation than cholecystectomy, but has a growing field of usefulness in all cases in which the gallbladder is involved.

Common duct operations, 207 cases. Group 1, consisting of those cases having gallstones in the common duct, operated during the quiescent period; jaundice and infection moderate; 105 cases; 3 deaths; 2.9 per cent. Group 2, 61 cases; 10 deaths; 16 per cent.; in which there was active infection, involving the ducts of the liver, and jaundice; patients suffered from Charcot's fever (fever and ague type); obstruction was severe, but not continuously complete. Group 3, 29 cases; 10 deaths; 34 per cent.; complete obstruction of common duct, in which no bile passes into the intestinal canal; elimination taking place by means of the kidneys and skin. Group 4, malignant disease; 12 cases; 4 deaths; 33½ per cent.; gallstones present in nearly all. Pancreas involved in 86 of the 1,500 cases; 4 acute, with 2 deaths; 6 subacute, with 1 death; 9 cancer, with 5 deaths; 67 chronic, without marked effect on the mortality.

PRIZE ESSAY.

This prize was instituted by the Medical Society of New Jersey at the annual meeting in 1905, and is open for competition to the members of the Component (County) Medical Societies.

The subject chosen is "The Symptoms, Etiology, Pathology and Treatment of Pneumonia."

The essays must be signed with an assumed name and have a motto, both of which shall be enclosed in a sealed envelope containing the author's name, residence and component society.

The essay shall contain not more than 4,000 words, and must be characterized by originality in investigation and thought, and by clearness and conciseness of expression, and be, in the judgment of the committee, of decided value to the members of this society, and to the profession generally. Failing in these respects, no award will be made.

The essays, which should be type-written, with the sealed envelope, must be placed in the hands of the committee on or before the first day of May, 1907.

The committee will select the first two essays in order of merit. To the first will be awarded the prize of one hundred dollars, to the second that of honorary mention.

The unsuccessful authors will receive back their essays upon their identification to the chairman of the committee. The successful essay will be the property of the society and be published in its transactions.

CHARLES J. KIPP, Newark, *Chairman*.

WALTER B. JOHNSON, Paterson.

DAVID C. ENGLISH, New Brunswick.

Committee.

Maternal Mortality Dr. James A. Harrar has a paper in the March number of *Bulletin of the Lying-In Hospital*, in which he refers to a series of 32,000 cases and the mortality among the mothers has been found to be 0.357 per cent. (114 cases), which is one death to about every 280 deliveries. The chief causes of death were sepsis, rupture of the uterus, eclampsia and placenta praevia, in the order named. Twenty-seven women, or about one in twelve hundred, succumbed to septic infection. The next most frequent cause of death after sepsis is rupture of the uterus; fifteen women died as the result of the accident. In five cases death occurred as the result of an internal version. Thirteen deaths were due to eclampsia, a mortality of 26 per cent. Three cases died after caesarean section had been performed. The fact that almost one-quarter of the total mortality was due to sepsis, a preventable cause, indicates in which direction the future mortality may be reduced.—*Medical Review of Reviews*.

Correspondence.

CAMDEN, N. J., SEPT. 13TH, 1906.

Dr. D. C. English, Editor.

MY DEAR DOCTOR:—I beg to thank you for the very kind editorial reference in the August issue of THE JOURNAL. The State Board of Medical Examiners of New Jersey is without a superior in this country, both in respect to its educational requirements and its methods of business.

As I stated at the meeting of the State Medical Society in June last, I am heartily in favor of the society recommending to the Governor, through its board of trustees, candidates to fill vacancies in the membership of the State Board of Medical Examiners. Since, however, the province of this board is to determine whether or not applicants for the medical license of New Jersey possess a reasonable academic and medical education, as defined by the present statute, I hope the Board of Trustees of the society will not overlook one point, namely: that the academic qualifications of the physicians recommended for examiners shall be at least substantially equal to the academic qualifications required of candidates for the medical license of this State. It is in the interest of the profession of the State that the Board of Trustees should ascertain specifically the educational qualifications and professional standing of its nominees and recommend only those who, by education and experience, *can meet the requirements of the statute*, in order to maintain our present relations with the examining boards of other states and the confidence of applicants for license. The profession, including the different schools of medicine, will undoubtedly support such an attitude on the part of the Board of Trustees.

Very truly yours,

E. L. B. GODFREY.

Dr. Marcy and the New York Life Insurance Co. on Medical Examiners' Fees.

RIVERTON, N. J., AUGUST 30TH, 1906.

Mr. J. G. Anderson, Comptroller, N. Y. L. Ins. Co., New York.

DEAR SIR:—Your letter, with check enclosed, duly received. I return same with a statement of my account. At the meeting of our State Medical Society, held in June, a resolution was passed making the minimum fee for such examinations \$5.00; your company has undoubtedly been notified to that effect by our secretary. I cannot accept less than this amount for such examinations.

Very truly yours,

ALEX. MARCY, JR.

NEW YORK, SEPTEMBER 6TH, 1906.

DR. ALEXANDER MARCY, JR., *Riverton, N. J.*:

DEAR DOCTOR:—Your communication of the 30th ult., addressed to Comptroller Anderson, has been referred to this department for attention.

In view of the fact that you have been making examinations for us under the terms of the Graded Fee Schedule and the further fact that you have not notified us that the schedule was not satisfactory to you,—we are at a loss to understand why your bill of August 30th should be rendered on terms other than therein provided. If you desire to notify us that hereafter you will not act for us under the provisions of the Fee

Schedule,—we shall, with much regret, be compelled to regard such notification as a resignation of your examinership.

Trusting that you will inform us as to your decision in the matter, we remain,

Very truly yours,

OSCAR H. ROGERS, M. D.,
Medical Director.

RIVERTON, N. J., SEPT. 14TH, 1906.

Oscar H. Rogers, M. D., Medical Director, N. Y. L. Ins. Co., New York.

DEAR DOCTOR:—Your favor of the 6th inst. duly received, and in reply would say: In the future I shall expect to be paid \$5.00 for any examinations I may be called upon to make.

It may be wisdom on the part of your company to reduce the fees for medical examinations, but I doubt it; for in addition to the fact of having incompetent men make the examinations, you will have incomplete and careless work done. In addition you will find a falling off in your new business, as the entire profession will very naturally favor those old and reliable companies who still pay the full fee. It would seem to me at least, that if the Medical Directors were alive to the best interests of the profession as a whole, to say nothing of the interests of the companies that they represent, they would put up such a protest that the trustees would not consider such economies as would in their operation strike at the very foundation of successful life insurance.

It will be interesting to note the difference in the mortality rate between the companies that pay \$5.00 for their examinations and those that do not.

Very truly yours,

ALEX. MARCY, JR.

[*Reference is here made to the resolution adopted at the last meeting of the State Society, a copy of which was sent to every life insurance company in this country.]—*Editor.*

CAMDEN, N. J., SEPT. 17, 1906.

To the Editor of the Journal:

DEAR DOCTOR:—About the first of July I was called upon by a man, representing himself to be a canvasser for the comparatively new medical journal, "Surgery, Gynecology and Obstetrics," who solicited my subscription. I did subscribe for the journal, and paid five dollars to the man, who represented himself to be Dr. G. E. Simpson, and received his receipt therefor, with the understanding that I would receive the publication for one year, from July, 1906. After waiting two months, and not receiving the July and August copies, I wrote to Dr. Franklin H. Martin, of Chicago, the managing editor, detailing the circumstances, and asking that the journal be forwarded to me. I enclose Dr. Martin's reply, in which he says the canvasser was "a fraud, and secured the subscription under false pretenses." I write this that other physicians may be placed upon their guard in reference to this particular canvasser; and would suggest that in all cases, the safer way is to deal directly with the publishers.

It is proper to say that Dr. Martin dealt very generously with me in the matter.

Very respectfully,

DANIEL STROCK.

LAKEWOOD, N. J., Sept. 25, 1906.

To the Editor of the *Journal of the N. J. State Medical Society*:

Dear Sir:—It was my privilege last week to attend the sixteenth annual meeting of the American Electro-Therapeutic Association, at Philadelphia. The sessions were held in the famous College of Physicians, lasted from Tuesday morning until Thursday evening, and were attended by about seventy-five fellows from all over the country. Dr. William Benham Snow, of New York City, presided, and of the thirty-two papers on the programme a large number were read in person. The papers were of unusual interest and marked a decided advance in electro-therapeutic knowledge during the past year. But perhaps the most striking feature of the meeting was the conservatism shown in stating results. Fault has been found in times past with the men who are enthusiasts in electro-therapy, that they are too sanguine and claim too much. This can no longer be said of them, as was proven most conclusively at this meeting.

A few of the more important papers were: "When are Electro-therapeutics Indicated?" Dr. A. C. Geysler, of New York City; "A Plea for Conservatism in Electro-therapeutics," Dr. A. D. Rockwell, New York City; "A Resumé of the Radio-metric Dosage of Roentgen Therapy," Dr. M. K. Kassabian, Philadelphia; "Clinical Demonstration of the Cataphoric Operation for Cancer," Dr. G. Belton Massey, Philadelphia; "Electrochemical Sterilization as Applied to Malignant Disease of the Orbital and Nasal Regions," Dr. G. Oram Ring, Philadelphia; "Experiences with Light in the Treatment of Various Diseases," Dr. H. Finkelpearl, Pittsburg; "Concentrated Light Energy," Dr. F. Barrett, Westbrook, Me.; "High Frequency Currents in Ophthalmic Cases," Dr. L. Webster Fox, Philadelphia. These few subjects will give an idea of the class of papers read and thoroughly discussed.

The Wednesday afternoon session was held in the new Oncological Hospital, and that of Thursday afternoon at the Medico-surgical Hospital, at each of which places luncheon was served. Dr. Morris Weil Brinkman, of New York, was chosen president for the coming year, and the session adjourned to meet at Jamestown, Va., in September, 1907.

Yours very truly,

W. G. SCHAUFFLER.

Pancreatitis.—Dr. JOHN M. MUSSLER, Philadelphia, delivered before the State Medical Society of Wisconsin, 1906, the annual address in medicine and made a clear statement of the pathology and differential diagnosis of the disease. He said that very little reliance can be placed on the condition of the blood in attempting to differentiate between affections of the gall bladder and pancreatitis. Leucocytosis is more pronounced in acute pancreatitis than in acute inflammations of the biliary passages. The stools are white or slaty and are large in amount in pancreatic disease. The neutral fat is relatively increased, but may occur in other conditions and may not occur in pancreatitis. The presence of nuclei in the feces, determined microscopically, is characteristic of pancreatitis. Take meat fiber, sew it in a little bag, let it pass through the intestinal canal and be recovered from the stool; the meat is then examined for nuclei. In patients who have not pancreatic disease the nuclei are always digested.

Excepting the nuclei test, laboratory tests are of little value because of the many qualifying circumstances that must be taken into consideration. With regard to the urine, more stress should be laid on the relative proportions of the ethereal sulphates present than anything else. It is a fair conclusion, then, that for a differential diagnosis of pancreatic affections we must still rely on close clinical observation and a careful study of the history of each case, availing ourselves of the aid (slight as it is) obtained from laboratory findings.—*Journal A. M. A.*, July 14, '06.

Early Operations for Cerebral Hemorrhages of Childhood.

—Dr. Charles H. Frazier, Philadelphia, said that in order to put on a rational basis the surgical treatment of epilepsy greater discrimination must be made in the selection of cases. No opportunity should be lost in operations on epileptic subjects to observe as closely as possible the existing pathologic conditions. A more intimate knowledge of the pathology of the disease is necessary for the establishment of a basis on which to determine the propriety of operative intervention and the character of the same. Epilepsy develops sooner or later in from 30 to 50 per cent. of cases of infantile hemiplegia. In many of these the lesion has been proven by autopsies to have been a hemorrhage, and in children the hemorrhage is often either on or near the cortex rather than intracerebral, as in adults. The tendency toward secondary degenerative changes, such as atrophy and softening, the greater disposition in epileptic subjects toward mental defects, especially idiocy, and the otherwise hopeless nature of the disease constitute the principal arguments for surgical intervention.—*Amer. Surg. Ass'n in Journal A. M. A.*

OPHTHALMOLOGY.

Antepartum Ophthalmia.—Stevenson and Ford (Ophthalmoscope, April) assert that cases of conjunctival infection developing within twenty-four hours after birth should be classed as antepartum ophthalmia, in view of the fact that the shortest period of incubation of conjunctival infection is forty-eight hours.

1. Instances of antepartum ophthalmia are not so uncommon as heretofore believed.

2. About one-half of the cases (44.5 per cent.) are satisfactorily accounted for by a premature rupture of the membranes, allowing access of the micro-organisms to the baby's conjunctival sac.

3. In the remaining cases (55.5 per cent.) a slight injury to the membranes may determine access of micro-organisms, or infection through the uninjured membranes must be assumed to have taken place.

4. Increased temperature of the conjunctival sac in utero enhances the virulence of the causative micro-organism. Feebleness of the babies, slight lateral tears of the membranes, position of the foetus in the maternal passages and the condition of the placenta cannot be shown to be connected with the causation of antepartum ophthalmia.

5. Several of the so-called anomalies of the eyes, such as corneal opacities, staphyloma, microphthalmus, cryptophthalmus, and lacrymal abscesses, are probably to be explained on the theory of an intrauterine infection.—*Dr. Higbee, in St. Louis Medical Review.*

Visual Disturbance at Childbirth.—S. Bauer. (*Monatsschrift f. Geb. und Gynaekologie*, Berlin, xlv.) records the case of a healthy woman who had suffered for three years with headaches, accompanied with nausea for the last three weeks of her pregnancy. Delivery proceeded rapidly and was followed by complete blindness, which on the fifth day passed into hemianopsia, with final recovery by the end of the month.

The treatment included repose, ice, with tonics for the heart, expectorants, and a remedy for insomnia. The eyes appeared normal except for a transient oedema of the retina, congestion of the veins, and a slight blanching of the right papilla. There was high fever for nine days following the onset of severe cerebral symptoms with a complicating endometritis. Considerable albuminuria was noted at first, but it soon subsided. The author reviews the scanty literature on the subject of postpartum blindness. In seven cases it was referred to uraemic or eclamptic toxins. Seven cases have been reported recently in which the presence of eclampsia without convulsions is discussed as the probable source of the symptom-complex observed. Bauer is inclined to accept this theory as the explanation of his case—all the symptoms and findings suggest the possibility of eclampsia, although no convulsions were observed. The blindness and its transition into hemianopsia were probably due, he thinks, to a toxic paralysis of the central optic nerve tracts affecting the right hemispheres alone.

Ulcus Rodens (Mooren).—Dr. H. H. Seabrook (*Medical Record*, March 31, 1906), says that the cause of this affection is unknown, bacteriological examination having been practically negative. He describes a patient, a perfectly healthy man, an actor, thirty-seven years old, with rodent ulcer of over eighteen months' standing. All the cornea except a small patch outward had been involved. Treatment of various sorts failed and the edge of the ulcer had reached the margin of the pupil. At this point pure carbolic acid seemed to check it, except for occasional relapses at the upper part of the ulcer, for several months, when the anterior layers of the cornea began to break down along the whole edge of the ulcer, except that directed toward the corneal limbus. Carbolic acid shortened the attacks and ameliorated the symptoms. Gray lines extended from the point of application into the lymph channels of the cornea. Dionine in 10 per cent. solution was used and vision already is equal to the best primary vision so far definitely recorded. There is a promise of fair appearance and useful vision in the course of time. The writer suggests some form of protozoan as a probable cause of the rodent ulcer of Mooren.

Vitreous Opacities in Young Girls.—Dr. C. J. Kipp, of Newark, N. J., (*Journal A. M. A.*, June 16th), quotes Hirschberg's reference in regard to certain enigmatical white tissue formations in the lower anterior portion of the vitreous body in girls and young women. Two cases are reported in which only one eye was affected, and Kipp remarks that such cases are probably not uncommon and have doubtless been observed by most ophthalmologists. He reports a third case, however, in which the condition, coming on during good health, was extensive in both eyes, causing practical blindness for a time. The opaci-

ties, however, gradually disappeared and vision was restored, though latterly cataractous symptoms have intervened in from twenty to twenty-five years after the first condition was observed. Kipp thinks that there were probably haemorrhagic effusions in the vitreous from the ciliary body antedating the opacities. The condition in this case so closely resembled retinal detachment as to deceive an experienced specialist. The participation of the choroid in the morbid process was shown by the appearance of an atrophic spot.

SUCCESSFUL OPERATION FOR CONICAL CORNEA.

Dr. Fred Stauffer, of Salt Lake City, Utah, (*Ophthalmic Record*, May, 1906), reports the case of a young lady, nineteen years old, who was operated on for conical cornea in the following manner: A small curved needle armed with a fine black silk ligature was passed through the cornea into the aqueous chamber about 2mm. to the nasal side of the centre of the cornea, and brought out above at a corresponding point. A second suture was placed through the cornea at the same distance below and above the centre on the temporal side. An elliptical piece about 3 mm. long was then excised from the whole thickness of the cornea between the sutures thus placed. The first incision was made with a Graefe knife by transfixing the cornea at the point where it was desired to locate the temporal angles of the ellipse and carrying the knife through the aqueous chamber, making a counterpuncture at the point desired for the inner angle of ellipse. The cutting edge of the knife was directed downwards and forwards and brought through to complete the lower incision. The desired amount of corneal tissue was then removed with a small pair of curved scissors. As soon as the excision was completed the sutures previously placed were tied, and the corneal wound was closed. Distance vision was brought up to 6-36 and the patient could read No. 4 Snellen type with proper lenses.

Obituary.

George F. Lightfoot, M. D., after several years' illness, from kidney disease, aged years. Dr. Lightfoot practiced in Arlington for 13 years, when he removed to Boston. Last summer he had an office at Asbury Park. Returning to Arlington for a visit, his condition became much worse and he was removed to St. Michael's Hospital, where he died. He was formerly a member of the Kearny Board of Health and served as health officer.

Morris—At his country home in Warren county, N. J., Austin F. Morris, M. D., August 22, from the effects of an automobile accident a year before, aged 38. He graduated at Bellevue Hospital Medical College, 1893.

Varick—In Mersemer, Bergen county, N. J., William Wilson Varick, M. D., aged 58. He was a graduate of Bellevue Hospital Medical College, New York City, 1876; a well-known practitioner of Jersey City; a member of the Hudson County Board of Health, and visiting physician to the Jersey City Hospital. He was a son of Dr. Theodore R. Varick, who was president of the Medical Society of New Jersey in 1863.

Personal.

Dr. David B. Ackley, of Trenton, was severely injured by an automobile accident last month, but has recovered. **Dr. Henry Allers**, of Harrison, enjoyed a trip to Niagara Falls and Buffalo. **Dr. Albion C. Christian**, of Irvington, has returned from a trip to the Pacific coast. **Dr. Launcelot Ely**, of Flanders, has been sojourning at Ocean Grove. **Dr. George H. Foster**, of Rockaway, has been visiting at Block Island, R. I. **Dr. Jacob Hempstead**, of Paterson, a graduate of Jefferson Medical College, Philadelphia, has succeeded Dr. Anthony as resident physician at Muhlenburg Hospital, Plainfield. **Dr. Francis E. Knowles**, of South Orange, has returned from Europe. **Dr. J. B. Pellet**, of Hamburg, is expected to return from his vacation trip October 2. **Dr. Meifford Runyon**, of South Orange, returned from Labrador September 20. **Dr. John L. Taylor**, of Boonton, has taken an extended trip through New York State and Canada. **Dr. Sidney Twinch**, of Newark, has enjoyed his vacation at Cragmore, N. Y. **Dr. Edwin M. Ward**, president of the Board of Health, Bloomfield, was stricken with paralysis recently while visiting a patient, but we are pleased to add that he has recovered. **Dr. E. G. Wherry**, of Newark, has been sojourning in the Adirondacks.

NEW MEMBERS OF THE AMERICAN MEDICAL ASSOCIATION FROM NEW JERSEY: **Bradford, Stella S.**, Montclair; **Gilbert, James S.**, Bordentown; **Smalley, Mahlon C.**, Gladstone; **Van Deestyn, H. T.**, Hoboken; **White, H. H.**, Hackensack.

MONTHLY STATEMENT OF MORTALITY— AUGUST, 1906.

By **David S. South**, Registrar of Vital Statistics, State Board of Health.

The estimated population for the State for August, 1906, is 2,178,87. The total number of deaths reported to the State Bureau of Vital Statistics during the month of August was 3,238. Infantile diarrhoea was the principal cause of death during the month of August, the number of decedents from this cause being 639, but this large number is in accord with the records of previous years, and is doubtless mainly due to the rapid bacterial changes in unclean milk which are produced by the high temperatures of the summer season. Tuberculosis of the lungs caused 272 deaths which is slightly above the average for this disease. Pneumonia caused 112 deaths, this being 50 less than during the previous month. Diseases of the digestive system (infantile diarrhoea excepted) caused 241 deaths. Diseases of the heart and circulatory system caused 261 deaths. Typhoid fever caused 28 deaths, which is slightly below the monthly average (32) for the past year. The mortality from diseases of the nervous system still maintains a high rate, but the number of deaths recorded as having been due to this cause (370) does not equal the average monthly rate for the previous year (426). Whooping cough was unusually prevalent, 42 deaths from this disease having been recorded.

Book Review.

MODERN CLINICAL MEDICINE.

Diseases of Metabolism and of the Blood, Animal Parasites, Toxicology; Edited by Richard C. Cabot, M. D. An authorized translation from "Die Deutsche Klinik." Under the general supervision of Julius M. Salinger, M. D.

New York. D. Appleton & Company, 1906.

Illustrated; 8vo., cloth; 649 pp.

This book is one of a series of clinical treatises which the Messrs. Appleton are bringing out from time to time. They are translations of a great German work, "Die Deutsche Klinik," which is being published in parts in that country and which has for its contributors men famous not alone in Germany, but all over the civilized world.

The volume before us deals with diseases for the most part of unknown etiology but of transcendent importance. Fortunately in the consideration of some of them very decided advances are recorded. The work is really a collection of about a dozen and a half monographs, each nearly or quite complete and independent of the others. These are for the most part tersely and succinctly written. The text is condensed, although there has been no attempt made to compress too much matter into a small space and the striking points, especially those relating to the etiology and treatment of the various maladies, are sufficiently elaborated. Fortunately for the busy man the sections are of a convenient length to be read at a sitting. Not to make an invidious distinction, in a work of such general excellence, the essay on "Chlorosis," by Grawitz, is perhaps the most interesting one in the book. And his contention that this condition is strongly allied, if not dependent upon, hysteria is so well taken and so ably defended that it deserves especial mention. If this assumption can be maintained, it promises to shed valuable light upon the etiology of that highly interesting, albeit obscure, series of conditions attributed to "nervous shock" or derangement of the nervous system, which includes arthritis deformans, diabetes insipidus, chorea, so-called idiopathic epilepsies, some forms of insanity and an indefinite number of conditions more or less loosely classed under the terms neurasthenia and hysteria.

That chlorosis may be an end result of coproptosis or may depend upon a congenital enyoplasia of the heart and arteries, as asserted by Virchow, Grawitz does not deny. He acknowledges a multiplicity of possible causes, but stoutly maintains that the basic lesion is a nervous derangement tending, generally speaking, toward spontaneous recovery.

Dr. Cabot's faithful editorial work is especially to be commended. In some instances his frank contradictions of the statements in the text are amusing as well as instructive. The printing, binding and proof-reading of this book are all that could be desired and an excellent index of authors and of subjects has been added.

This set of translations promises to be a most welcome addition to medical literature.

R. C. N.

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THE SURGICAL TREATMENT OF GASTROPTOSIS.*

By Henry D. Beyea, M. D., Philadel-
phia, Pa.

*Associate in Gynecology, University of Pennsyl-
vania; Associate Surgeon, Gynecean Hos-
pital; Assistant Gynecologist,
University of Pennsylvania.*

Four years ago I had the pleasure of presenting before this society the subject of gastroptosis and described to you an original method of surgical treatment, the elevation of the stomach by the plication of the gastro-hepatic and gastro-phrenic ligaments. At that time the surgical treatment of this condition was little recognized and had been practiced in but a few cases, then mostly experimentally. It is my purpose now to place before you the results of my further study and a wider experience in the surgical treatment.

Within the last few years the diseases of the stomach have come to be looked upon in a sense of new importance. We no longer take it for granted that pain and distress in the epigastric region is simple indigestion or dyspepsia, to be treated by the administration of such drugs as pepsin and subnitrate of bismuth and advice as to diet, but it is imperatively demanded of the practitioner of medicine, the internist and surgeon that such pain be carefully investigated as to its cause by certain methods of physical examination, with, if necessary, inflation of the stomach or an accurate study of the physio-

logical function. The diagnosis made, a definite medical or surgical treatment is to be decided upon and carried out. The influence of disease of the biliary apparatus in the production of indigestion is understood and the remedy is surgical. Gall stones disease is now common, a short time ago it was a rare disease and a medical one. The same may be said of ulcer, carcinoma and other organic lesions of the stomach. The functional diseases of the stomach, and among them downward displacement or gastroptosis, have received a share of consideration, but not the same degree of investigation and research as those more important, vital lesions referred to. Still there has been a distinct step in advance. In the diagnosis of gastroptosis the X-ray has recently given us not a little information. Through the administration of a mucilage of acacia solution of subnitrate of bismuth, a coating of the stomach walls with this metallic powder is gained, which, resisting the rays of the X-ray gives a definitely true outline in picture of the ptosed stomach. Not only is this method of value in diagnosis, but its use has demonstrated beyond doubt the inefficiency of the abdominal support or binder aiming to elevate the ptosed stomach. The investigations of Worden and Sailer in this direction show that the binder has practically no influence on the position of the stomach. I might also here state that the X-ray picture, taken after operation, has pointed out that the surgeon cannot restore the stomach to too high a position beneath the liver.

The treatment of gastroptosis is still largely a medical one, and although it is

*Read at the 140th annual meeting of the Medical Society of New Jersey.

now recognized that the condition is congenital in origin, the cause abnormally long ligaments, and that no medical or non-surgical mechanical means has been, or can be, devised to elevate the stomach and correct the cause, still the surgical treatment, generally speaking, because it necessitates an abdominal incision and is followed by some shock to the nervous system, it is believed is not warrantable except where the suffering is extreme. The advance in the surgical treatment is evidenced by the fact of the recognition and illustration of the operation of gastropexy, described to you at the previous meeting, in every modern textbook or other recent work on surgery. The total number of operations which had been performed four years ago by this method was 7, to-day the number is at least 30 or 40. The method of operation will be recalled to your minds by the illustration in Moynihan's recently published work—"Abdominal Operations." The principle of this operation is that by placing three rows of interrupted silk sutures from above downward, and from right to left through the gastro-hepatic and gastro-phrenic ligaments, through the peritoneal tissues of the gastro-hepatic omentum, a single, broad transverse fold or plication is formed in the ligaments, thus shortening the normal ligamentary supports and elevating the stomach to normal position. The normal anatomical relations of the organ are restored, the cause of kink at the pylorus and gastric dilatation is corrected, and therefore the conditions favorable to restoration to normal physiological function is gained. The operation is simple in technique and easily accomplished by any well trained abdominal surgeon.

Since April, 1898, we have performed this operation in eight cases; it has also been carried out in two cases by Dr. Edward Martin, in three cases by Dr. Charles P. Noble, in one case by Dr. Edward Hodge, and in three cases by the Mayo brothers, of Rochester, Minn. Bier, of Grieswald, Germany, reports four cases operated upon by practically the same method, and Eve, of London, has just reported four cases operated upon by a similar method. In all we know 25 cases have been operated upon by plication of the gastro-hepatic omentum. In the cases operated upon by myself 8, Martin 2, Bier 4, representing those of which we have been able to gain any accurate report, a total of 14 cases, the patients had suffered from 5 to 15 years with the characteristic and very severe symptoms of gas-

troptosis. All but one was emaciated, weighing between 78 and 123 pounds. In every instance the form of gastropexy was the subvertical and pronounced. In 7 the upper curvature of the stomach was at or just below the umbilicus. In three, two inches above the umbilicus. In four midway between the umbilicus and xiphoid cartilage. In three a dilatation of the stomach was also diagnosed, but this was not demonstrable at the operation. In none of the cases was there a diastasis of the recti muscles, although four had borne children. In every case the severe symptoms of gastropexy rendered the patient a chronic invalid, and incapacitated her for any occupation or social duty. All had been treated faithfully for a great length of time by the medical methods advocated; with medicine, hygiene, diet, bandages and the rest cure, and in six of the cases reported by me the physicians insisted that they were unable to give their patients relief, and the patients were at once willing, because of their suffering, to risk the danger of operation for the sake of a possible cure.

These fourteen cases have now been observed for a period ranging from three months to eight years. In two cases the patient has but recently left the hospital and no estimate as to the effect of the operation can be made. In one case operated upon three years ago, a profoundly neurasthenic woman with the lavage habit, improvement took place slowly, she gained about fifteen pounds in weight and was quite well until this winter, when, after nursing two sisters, separately, through a long course of typhoid fever, her symptoms returned. She now writes me that she is no better, and is practicing lavage and daily irrigation of the colon. I may say here that preceding operation we recognized the element of neurasthenia in this case, was doubtful regarding the benefit to be received, but no other method of treatment had been of any benefit. We felt that we were driven to operation even though it was an experiment. In every other instance the improvement in health has been most remarkable and the relief of symptoms complete; the dyspeptic and neurasthenic symptoms are entirely relieved, food of any character is taken without restriction. All have gained markedly in weight and, (with the exception of one of Dr. Martin's cases, also a profoundly neurasthenic woman), the gain in weight has been lasting and gradually increased with time; one after eight years, the first case operated upon, having gained 40 pounds and

another after six years 25 pounds. In no instance, as far as we can determine regardless of the time which has elapsed since operation, has the stomach changed in position. In the case referred to, operated upon by Dr. Martin, the patient gained twenty-five pounds in weight, afterward lost part of the weight gained, but remained greatly improved in health.

There has been no mortality following operation, never any distinct amount of shock, and the convalescence following as easy as that of any very simple exploratory abdominal operation. The patients, we have noted, have been particularly free from either nausea and vomiting, or from nausea and vomiting as caused by the following purgation treatment, which fact we have thought to explain through the new position of the stomach, causing complete drainage. The mortality of the operation, comparing it with that of a simple exploratory coeliotomy, I estimate would not be greater than one-fourth of one per cent.

From a study of the cases reported in the literature, including the instances where the operation performed was a fixation of the stomach, and particularly from personal experience, it is my belief that the results of surgical elevation of the stomach for gastropotosis are as satisfactory and as beneficial as that of any operation performed for the relief of any condition in surgical practice. A chronic invalid in the large majority of cases is restored to excellent health. For the present it is our opinion that the operation is applicable and indicated in every case of gastropotosis not made comfortable and able to assume an occupation and social duties by a thorough application of the medical treatment. With further experience we believe it will be found warrantable to perform this operation in every case of gastropotosis complaining of the symptoms of gastro-motor insufficiency, in every case where the internist now prescribes the constant wearing of an abdominal support, diet and hygiene. I need not, however, point out that the operation will not relieve an essential neurasthenia where the neurasthenia is the first and prominent cause of illness, and the gastropotosis of secondary importance. Nor that it will cure a case where the symptoms are due to a condition of general visceral ptosis, splanchnopotosis, but in my experience those cases are very rare. The operation is not, of course, necessary or indicated where the ptosis of the stomach is not causing symptoms and ill-health.

Gastropotosis, as I have said, is now considered to be a congenital condition. The gastro-hepatic omentum, the normal ligamentary support of the stomach, is found to be congenitally of abnormal length, and through the presence of this abnormally long ligament the stomach is found to lie even in a vertical position in the abdominal cavity. The changes which here take place in the motor power of the stomach are as far as we know the direct result of the ptosed position. The abnormally long gastro-hepatic omentum is composed of connective tissue, a tissue which by no medical or non-surgical means can be made to contract or be shortened to elevate the stomach to normal position. The experiments with the X-ray, recently reported by Drs. Worden and Sailer, definitely determine that the abdominal binder, which must aim to increase the abdominal pressure and thus elevate the stomach, has in truth no influence on the position of the ptosed stomach. The bandage does good, if it ever actually does do good, by simply giving support to the abdominal blood vessels. The diet, hygiene and the administration of drugs aiming to prevent fermentation of food and increase the tonicity of the gastric musculature there can be no doubt give much relief as long as they are applied, and the patient is able to get on, from a medical standpoint, comfortably under these conditions. The patient, however, remains a chronic invalid, for he lives on a special diet, is constantly under the care of a physician and must wear a cumbersome bandage. The cause of the condition and its symptoms are never removed. Provided the danger of the operation of elevation of the stomach is not greater than one-fourth of one per cent., the shock following but very slight, the course of invalidism at most two months following operation and the result of the operation at least a satisfactory restoration of health in surely seventy-five per cent. of the cases, I would ask is the medical, dietetic, hygienic and bandage treatment warrantable or justifiable?

DISCUSSION.

Dr. Gordon K. Dickinson, of Jersey City.—

I am probably not the proper man to discuss the paper on this topic because I have never seen nor operated upon a case. In looking over the literature, such as I have, I cannot discover anything pertaining to it. I am delighted to see the doctor meet the condition, however, by some method other than the operation of gastro-enterostomy. I am surprised, too, that such permanent results can be obtained from a plastic operation upon the gastro-hepatic ligaments which contain such a small quantity of fibrous tissue. The results

which he has brought out certainly prove that he has given the profession something of value.

Dr. Charles P. Noble, of Philadelphia—I have been glad to hear the paper just read because it shows the resources of medicine and surgery in the development of the operation. From my standpoint our chief difficulty is the lack of exact knowledge concerning the general question of gastropotosis, splanchonptosis, enteropotosis, etc. Personally I think that medical men are very apt to exaggerate the frequency with which all the internal viscera are prolapsed; in their discussions they assume that if a kidney drops all the other organs drop. I am satisfied after studying this question for fifteen years that this is an exaggerated position. This year at the American Gynecological Society I heard a paper on this subject backed by X-ray pictures. It was a beautifully prepared paper and drew deductions from 20 X-ray pictures. In the study of this question one is inclined to draw broad deductions from narrow facts. So far as this is concerned my own opinion is that the stomach drops often when the other viscera do not. This is true of the uterus. Therefore, I am satisfied if you can cure a dropped stomach you will often cure the only trouble a patient has. My experience is with three patients, two women and one man, practically all cured. They had been miserable invalids. One patient was a crank and died a crank; her chief trouble seemed to be in her head and she also had dropped kidneys, dropped stomach, a torn perineum, etc. When she fell into my hands I repaired the position of the organs and also did an Alexander. Then she was sent to a stomach man, but she tired of him and came back to me and I referred her to a neurologist. She was given the rest cure, but she was as cranky as before. The kidneys were stitched and she was given a rest in the hospital, but she was as bad as ever. The stomach was sewed up and she was equally as bad. In other words some people are cranks and you cannot make anything else out of them. I heartily endorse what Dr. Beyea has stated so far as the proximate results are concerned, especially when you are dealing with these neurotic patients. So far as the technique is concerned I operate as Dr. Beyea, using the mattress sutures for the gastro-phrenic and hepatic ligaments because they are more tensible and strong. Coffee invented an operation but instead of suspending the stomach from the top he hung it up from the bottom. After I do the Beyea operation I do the Coffee operation and my results are good. I myself can see no objection to doing the two operations. We all know that omental adhesions do not as a rule produce symptoms. Attaching the colonic omentum to the anterior abdominal wall will not interfere with the motility of the stomach. Other operations are done to plicate the stomach, and the stomach is stitched to the abdominal wall and good results have been reported. Therefore, I have satisfied myself that in selected cases the Beyea operation added to the Coffee operation will give good results and I hope surgeons will study these cases in order that we may get enough material to form adequate and proper conclusions. At the present time this is merely experimental.

Dr. Frank D. Gray, of Jersey City.—I have not the temerity to discuss the paper, on account of

lack of experience, but I would like to ask one or two questions. In the first place, would it not be feasible, and possibly be an element of time saving, instead of using the mattress sutures, to use the continuous suture over a piece of rubber tube, then withdrawing it, and continue plicating in the same manner? The only objections seems to be in interfering with the circulation in the gastro-colic and hepatic omentum.

Again it seems to me there should be a more thorough understanding of this method, on the part of physicians, especially of the pathologic condition for which it is used. Am I right in understanding that it applies to gastropotosis and not gastrectasis?

Dr. George H. Balleray, of Paterson.—As regards the pathology of the disease, the doctor says it is congenital, but I think it is due to the patient's mode of life. It occurs mostly among the female sex and my idea is that, in the majority of the cases, prolapse of the stomach is often the result of faulty methods of dressing, tight corsets, skirt bands, etc. As a rule they are neurasthenics; there is a general prolapsus of the viscera; sometimes of the uterus, sometimes the kidney is movable, and all of the organs are in a condition of ptosis. There is an absorption of intra-abdominal fat. The benefit of an operation upon a movable kidney comes largely in keeping the patient in bed and allowing a reaccumulation of fat. I believe this is a point that should always be considered in these cases. I do not believe we should be in too great a hurry to suspend the stomach. If the patient after an operation does not improve in health the prolapse will recur. I do not believe that we are able to get support enough to overcome the tendency to prolapse unless a certain amount of padding was had by this accumulation of fat; the abdominal wall and omentum should have a certain amount of fat to bring about what Matthews Duncan called "the retentive power of the abdomen." The operation is merely a step in the cure; cure really is the result of confinement in bed and improvement in the general condition. We all know that certain mental influences are exerted by surgeons in those cases. We promise patients that the operation will exercise a beneficial influence and, to a certain extent, play the part of Christian scientists. The moral influence is an advantage.

Dr. Henry D. Beyea, of Philadelphia.—We all, of course, recognize the fact that a patient may have a general visceral ptosis and that such patients are as a rule profoundly neurasthenic. In my experience, however, this general condition of ptosis is very rare. In the very large majority of cases there is present a simple gastropotosis of varying degree, in a few associated with nephropotosis. In the discussion of the use of this operation at the Saratoga meeting of the American Medical Association it was stated as the opinion of one of the gentlemen that the relief gained was due to the three weeks in bed following operation to a rest cure. The shock of an abdominal operation, even though the shock be slight, is sufficient to overbalance a rest cure of three weeks, and in my experience it would, if the cause were not removed, increase the neurasthenia. The results obtained, to my mind beyond a question of doubt, were accomplished through the mechanical reposition of the stomach and return of its

physiological function. The restoration of health has been so complete that any one must consider it most remarkable. Take for example the first case operated upon. The patient had been an invalid for six or eight years, an invalid to the extent that she was almost constantly in bed. She had been treated carefully and skillfully by the late Prof. William Pepper for three years. The rest cure was more than once given a thorough trial by him, likewise every known medical and mechanical treatment, but she still remained a miserable invalid. She was so ill and unhappy that at once she accepted the suggestion to undergo an operation which was to be a pure experiment, an operation the danger of which we could not estimate or state that it would not fail to give her any relief. She was told that it was possible it might make her worse. Remembering that we knew of no such surgery or that our planned procedure would in any way be efficient. Eight years have elapsed since this operation. She was within a month after getting out of bed relieved of many of her symptoms and began to gain in weight. In about a year she was restored to excellent health, had gained forty pounds in weight, and in January of this year, the time I heard of her last, she was taking care of her household duties and considered herself to be a strong and healthy woman. The mental impression of a surgical operation and three weeks rest cure I cannot believe would have relieved this woman so completely and constantly for eight years. It could only have been the replacement of the stomach to normal position and the assumption of normal function. It has recently been stated by an English surgeon that the connective tissue forming the gastro-hepatic omentum, the gastro-hepatic and gastro-phrenic ligaments, is not sufficient in quantity or strength of texture to hold the sutures and support the stomach, that they were so thin and delicate he scarcely dared to touch them. This has certainly not been my experience. Before attempting to shorten these ligaments by suture in the living, the operation was planned and carried out on the cadaver. I found at the completion of the operation on the cadaver that not only was there sufficient material connective tissue to suture, but that at the completion of the operation it required even great force to tear the stomach loose from its new attachments. In every one of the eight cases I have operated upon I believe the same to be true—that the strength of the support was more than sufficient. Further, in the first case, after three years, examination determined that the stomach had not changed in position. It was the opinion, it could not have been the actual experience, of the English surgeon that the sutures would not hold.

I cannot agree with Dr. Noble that the Coffee operation is ever advisable as an additional support. Coffee's operation, indirectly attaching the stomach to the anterior abdominal wall and more or less fixing the stomach, must interfere with its peristaltic action and is certainly unsurgical, and particularly would I condemn it because it is wholly unnecessary. Regarding the use of tubes in the plication of the ligaments I would say such a procedure is not practicable. It is very necessary in performing this operation to introduce the sutures as high as possible at the hepatic attachment and the sutures must all be introduced before any one is tied. There is not sufficient operative area to introduce the sutures and

immediately tie them. In order to gain the greatest operative area and place the sutures at the highest and lowest points it is advisable to place the patient in the reverse Trendelenberg position and displace the stomach downward out of the wound by means of gauze pads. The ligaments are thus placed on the stretch and the sutures are most easily introduced. As to the presence of dilatation of the stomach with gastropnoxis it has not distinctly existed in any of my cases. In three instances a dilatation was diagnosed but could not be demonstrated at operation. If an associated dilatation of the stomach does exist it is nearly always secondary and dependent upon the gastropnoxis. Therefore, we believe if the position of the stomach is restored the dilatation will soon disappear. If there exists a primary dilatation and the stomach is ptosed, it would perhaps be wise to do gastroplication.

THE ETIOLOGY, PATHOLOGY AND TREATMENT OF FIBROID TUMORS OF THE UTERUS.*

By George H. Balleray, M. D.,
Paterson, N. J.

Etiology. As regards the etiology of uterine myomata but little is known, and therefore the less we say on the subject the less likely we are to expose our ignorance. Fibroid tumors of the uterus are far more common in women of the negro race than among white women, while ovarian tumors are much more common in the latter. Uterine fibroids almost never occur before puberty and very rarely develop after the menopause. It is claimed that heredity plays an important part in the causation of uterine myomata.

Pathology. The most frequent morbid changes occurring in uterine fibroids are fatty degeneration, mucoid degeneration (the so-called fibro-cystic tumor of the uterus), malignant changes, septic infection and gangrene. Calcareous degeneration occurs in these growths, but it is of little interest to the practical surgeon. Pregnancy is an occasional complication of uterine fibroids. It is not the intention of the writer to go into a detailed description of the pathological changes occurring in fibroid tumors of the uterus, they will therefore be referred to only as an indication for treatment.

Treatment. The treatment of fibroid tumors of the uterus should be divided into palliative and operative. The palliative treatment finds its application in the relief of pain or hæmorrhage. Where a tumor of the uterus becomes incarcerated in the pelvis, and by pressure upon the bladder,

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rectum or large nerve trunks causes pain, it should, if possible, be raised above the pelvic brim. This is best accomplished by the intelligent application of digital force, the patient being in the knee-chest position and the rectum and bladder having been previously emptied. When the tumor is small the uterus may be retained *in situ* after reduction, by a Hodge pessary with a suitable curve. The bowels should be regulated by mild laxatives and the patient should wear a corset-waist and loose skirt-bands; heavy skirts should be suspended from the shoulders, not from the waist.

Haemorrhage is often the worst complication of uterine fibroids. At times it is so profuse and so persistent as to threaten the patient's life. In all cases the frequently recurring metrostaxis exhausts the vital powers of the patient. There is a condition of hydraemia and the various organs and tissues of the body suffer from malnutrition. In long standing cases degenerative changes in the heart muscle are prone to occur. The palliative treatment of haemorrhage caused by uterine fibroids consists in removing all constriction from the waist, in order that the venous circulation in the pelvic organs may not be impeded. Constipation should be overcome by suitable laxatives. In cases in which the haemorrhage is severe or almost continuous, rest in bed is essential. When the drain on the vital fluid has already been marked the foot of the bed should be elevated to keep up, as far as possible, the blood supply to the brain. The hydrochlorate of hydrastin may be given internally, or ergotin or Squibbs' fluid extract of ergot in combination with fluid extract of liquorice to make it more acceptable to the palate. Internal remedies, however, have as a rule but little effect on the haemorrhage and are not to be depended on to the exclusion of more reliable means. Vaginal douches of sterile water at a temperature from 110° to 120° are often useful, especially in cases in which there is a constant oozing of blood, but no active haemorrhage. In the tampon, if properly applied, we have a most reliable remedy, but every consulting gynaecologist and obstetrician knows how few physicians there are who apply a tampon properly. It is not unusual to be called to a case of haemorrhage in which the medical attendant has tried to control the bleeding by a few narrow strips of gauze, or a few wads of absorbent cotton, stuffed into the vagina at random. What good could be expected to come from the use of such a tampon as that? "If a thing is worth doing, it is worth doing

well." In the application of a tampon for the arrest of bleeding from a fibroid, the uterus and bladder should be emptied and the vagina, having been previously disinfected and the patient placed on a table in Sims' position, the cervix should be exposed by a Sims' speculum and a narrow strip of iodoform gauze carried by means of a suitable forceps to the internal os, and the cervical canal having been packed, the remaining portion of the strip of gauze should be placed over the external os and around the cervix. Another strip of iodoform gauze, an inch wide, should be placed in front and behind the cervix, and thus the whole vagina should be thoroughly filled with strips of plain sterile gauze an inch or two inches in width. A sterile pad should be placed over the vulva and a T-bandage applied. A tamponade of this sort rarely fails to control the bleeding completely. The tampon should remain *in situ* forty-eight hours and should then be removed and the vagina, having been disinfected by strips of sterile gauze dipped in a weak antiseptic solution, replaced if necessary. While the tampon is in place, if the patient cannot urinate voluntarily, the bladder should be emptied every eight hours with a thoroughly aseptic soft catheter, properly lubricated with sterile vaseline. The absurd practice of using a dry catheter should be condemned—such sand-papery of the urethra is often productive of harm.

If iodoform gauze is used it is unnecessary to change the tampon oftener than every forty-eight hours: whereas, if plain gauze is used it often emits an offensive odor at the end of twenty-four hours. The fear of iodoform poisoning is, I believe, entirely without foundation. I have used iodoform gauze for packing the vagina and uterus and for draining the pelvis in hundreds of cases and have never seen a case of iodoform poisoning. I have been called in consultation a few times to see cases of supposed iodoform poisoning, but they proved to be cases of acute sepsis.

Women who are suffering from fibroids and bleed freely at each menstrual period often become very anaemic, and their blood loses its properties of coagulability. As the woman loses more blood during the menstrual period than she can make in the intermenstrual period the monthly balance is always against her. In a case of this kind it has been my practice for years to direct that after the flow has been present for two days the vagina should be tamponed as

above directed. This stops the excessive flow at each period and in the course of a few months a marked change for the better is manifest in the patient's appearance. In women approaching the menopause this treatment often carries the patient safely beyond the critical period, and in many cases the tumor disappears entirely during the retrograde metamorphosis of the uterus incident to that period of life. I have seen many such cases.

Operative Treatment. The surgical treatment of uterine myomata resolves itself into two operative procedures—myomectomy and hysterectomy. In all pedunculated growths, and in all cases in which enucleation is practicable, without inflicting too great injury upon the uterus, myomectomy should be preferred, especially during the child-bearing period. This conservatism should not, however, be carried to an extreme degree, for at times the more radical operation is the safer one. The judgment of the surgeon, based on experience, will determine his choice of operation in a given case. The question as to whether the tumor, or the uterus and tumor, should be removed by the vaginal or abdominal route is often a question of relative experience and skill on the part of the operator. The surgeon who has performed a large number of operations by the vaginal route and but few by the abdominal will naturally prefer the former, whereas the operator whose experience is limited to abdominal operations will naturally select the abdominal route. I think that it may be truly said of this, as of many other matters, that "That which is best administered is best." The rule that small tumors should be removed through the vagina and large ones through the abdominal wall holds good, however, in spite of individual preference based upon individual experience. A surgeon as expert as Ségond may safely remove, in a few minutes, through the vagina a fibroid reaching almost to the umbilicus, but if a tyro attempted such an operation he would soon find himself in deep water and would probably wish that he had attacked the tumor from above, or not at all. For the inexperienced man the abdominal operation is undoubtedly the safer one.

As regards the relative merits of supra-vaginal amputation and pan-hysterectomy, or the combined method, I have no hesitation in saying that my preference is entirely in favor of supra-vaginal amputation; and "I have a reason for the faith that is in me,"

for whereas pan-hysterectomy and the combined method have given me a mortality of *ten* per cent. supra-vaginal amputation, even in complicated cases, has given me a mortality of only *two* per cent. In my opinion, pan-hysterectomy and the combined method should be limited to cases in which, in addition to the fibroid tumor of the body of the uterus, the cervix is the seat of malignant disease.

Indications for Operation. The existence of a fibroid tumor of the uterus is not in itself an indication for radical operation. On this point Kelly, in his work on "Operative Gynaecology," says: "I feel it my duty to enter an urgent warning against accepting the simple fact of the presence of a tumor as a sufficient indication for operation. The conscientious operator should always be able to show either that the continued presence of the tumor is in some way a menace to life, or that its presence is incompatible with a comfortable existence." Pain, haemorrhage and rapid, or steadily persistent growth of the tumor are the real guides by which we should be influenced in our decision in these cases. As regards pain it may be said that if a tumor which is incarcerated in the pelvis causes severe pain which cannot be relieved by the method previously spoken of, its removal is indicated. Pressure of the tumor upon the ureters is also an indication for operation. Profuse or persistent haemorrhage, which resists the palliative treatment outlined in the earlier part of this article, calls for relief by radical means. In some cases the patient has been so reduced by the haemorrhage that it is necessary to keep her in bed, feed her generously with milk, eggs, cocoa and concentrated broths and control the bleeding by tamponing, until her condition improves sufficiently to warrant the surgeon in exposing her to the dangers of an operation. I have seen several cases in which the percentage of haemoglobin was reduced below 30 per cent., but the patients improved under the treatment above indicated and were subsequently operated upon with success. It often happens as a patient approaches the menopause that the haemorrhage, caused by a fibroid tumor, increases at each menstrual period and by some surgeons this is looked upon as an indication for radical operation. I do not so regard it. I have met with many cases in which the palliative treatment which I have advised has so controlled the loss of blood that the patients have safely passed the menopause and the

tumor has subsequently disappeared. Some good surgeons deny that this ever occurs. Of course, if a surgeon removes every uterus that he meets with which is the seat of a fibroid tumor he will never know what the efforts of Nature, aided by judicious palliative treatment, can accomplish. This is the exact condition in which many surgeons find themselves and, therefore, their opinions on this point are not worth much. I have seen over sixty cases in which fibroid tumors, varying in size from an orange to a large cocoanut, have entirely disappeared after the menopause. These cases were under observation for a period of many years and there was no question as to the correctness of the diagnosis. In this connection I will briefly refer to pregnancy as a complication of uterine fibroids. I do not regard the occurrence of pregnancy as a complication of uterine fibroids as a reason why the medical attendant should at once develop hysterical symptoms. This, however, seems to be not uncommon. With some practitioners such a complication seems to be a sufficient reason for rushing in and doing all sorts of formidable things. My advice to such would be the same as Puck's advice to those who contemplate marriage—Don't! Nature is conservative, and it is sometimes astonishing to note how she adapts herself to a change of surroundings. I have met with a considerable number of cases of pregnancy and labor complicated by uterine fibroids and in some the tumor was so large and so placed as to offer a serious obstacle to delivery, and yet in every case but one the tumor entirely disappeared within a few months after delivery. In one case which I saw in consultation with Dr. Thomas F. O'Grady, of Paterson, and which was seen with me by my friend and former colleague, Dr. C. S. Van Riper, now of Pasadena, Cal.; the woman who had been married several years and never been pregnant, and who had had for a long time a fibroid tumor the size of a pregnant uterus at full term, had missed three menstrual periods. The bluish discoloration of the vagina, the changes in the breasts and the persistent nausea and vomiting, left no doubt in my mind that she was pregnant. Dr. Van Riper examined her at my request and advised that the uterus be emptied. This I declined to do fearing that an artificial abortion, under such circumstances, might be disastrous. Fortunately for the patient she aborted spontaneously at the fifth month. She was sent to St. Joseph's Hospital and

carefully watched, but no untoward symptoms manifested themselves, and she left the hospital in three weeks. I saw her after that from time to time for several months and found that the tumor was gradually diminishing in bulk. The last time I examined her the tumor was not larger than a large cocoanut. Dr. O'Grady tells me that the growth entirely disappeared and that he attended her about three years later, in labor at full term, that she gave birth to a healthy living child and is now in perfect health. Of course, all cases of uterine myoma, complicated by pregnancy, do not have a favorable termination. The labor may be obstructed and the case may call for the exercise of the best skill and judgment on the part of the medical attendant. In cases in which the tumor is so situated as to obstruct the birth canal, and render delivery *per vias naturales* impossible, Caesarean section should be resorted to. I have, however, succeeded on several occasions in delivering, by version or long forceps, women who were the subjects of large uterine fibroids so placed as to offer an insurmountable obstacle to delivery by the natural efforts. Violent efforts at delivery by forceps or version are to be condemned. A clean Caesarean section, done when the woman is in good general condition, is infinitely safer in skillful hands than version or forceps operations done by an inexperienced or unskillful practitioner. The operation to be selected in a given case is a question of judgment based on experience. There is no procrustean bed in the practice of obstetrics, and the inexperienced should not assume the liberty of action which belongs to the expert. Infected or sloughing fibroids call for immediate operation. Malignant changes in uterine fibroids are of rare occurrence, but nevertheless they do occur.

When a woman approaching the menopause has, in addition to discharges of blood, a discharge of a foul smelling watery fluid, resembling the washings of meat, and the tumor shows a tendency to enlarge, no time should be lost in resorting to a radical operation.

DISCUSSION.

Dr. Edward J. III, of Newark. The question of fibroids has of late received new interest. I want to say one thing about malignant degeneration of fibroids. The question has been held up so long that really we are beginning to be afraid of it. However, if you will look over the statistics of Johns Hopkins Hospital you will find 1,310 cases reported of uterine fibroids and only one which seemed to have undergone malignancy.

nancy. On the other hand cases of fibroid tumors are often accompanied by malignancy in other parts of the uterus or pelvic organs, as of the cervix, the rectum or the body of the uterus itself. Dr. Noble, of Philadelphia, has shown this to be the case by most laborious and painstaking statistics. But malignancy occurring in the fibroid itself, or malignant changes in the fibroid, I have never seen. If the fear of malignant degeneration of the fibroid itself is made an indication and we take the Johns Hopkins report as a standard, and furthermore if the death rate is 4 per cent from the operations, then we are killing over forty times as many patients because we fear malignancy, than if we let all cases go. Cases of fibroids should be watched carefully; while they may increase very rapidly in size before menstruation they decrease again afterward and then are best treated by the use of cotton root fluid extract in thirty drop doses one week before and during the menstrual period. This has a marked influence on their size. At some future time I shall publish a list of cases treated and measured during the twenty-five years past.

When we speak of conservatism in operations for fibroids, we only mention myomectomy; that of course is along conservative lines. There is another operation which I have performed, removing all the uterus above the os internum, leaving part of the body and one ovary. These patients continued to menstruate. The indications for any operation, no matter what it is, must be carefully drawn. The indications for the removal of the uterus must be carefully drawn. Many cases of fibroids remain perfectly well, giving no symptoms and there is no reason for operating. Dr. Noble, of Philadelphia, whose work regarding these tumors we so highly respect, has worked out to his satisfaction the theory that it is actually necessary to remove all fibroids because of the great many changes which occur in them. As somebody has stated 4 per cent. of all post mortems on women over 30 years of age have fibroids. If that is true then 100,000 women are walking about Philadelphia and within a radius of fifty miles, with fibroids. With regard to that bugbear, pregnancy and uterine fibroids, I can only say of 20 Caesarean sections only one was performed because the fibroid obstructed the passage of the child. I have many times expected to do a Caesarean section but there followed a retraction of the lower segment of the uterus and an ordinary labor followed.

Dr. George H. Balleray, of Paterson.—

I wrote this paper because I found radicalism the order of the day, all writers favoring the removal of every fibroid present, and on the ground that dangerous changes might take place. I am glad Dr. Ill has brought out as forcibly as he has that there are but few cases in which malignancy has taken place in these uterine growths.

There is one point not spoken of, that is, the treatment of hemorrhage by curettage. I have seen it do harm. The treatment I suggested is absolutely innocuous, does not harm the patient and accomplishes all that can be accomplished. With regard to pregnancy complicating uterine fibroids, I wrote a paper in which I reported a number of cases of fibroid tumor of the uterus complicated by pregnancy, or rather pregnancy complicated by fibroid tumors of the uterus. In

several of them it was extremely difficult to deliver. In every case, within eighteen months from the time of delivery, the tumor, which was sometimes found to be as large as a uterus at the sixth month of gestation, had entirely disappeared. For that reason I do not think there is any great occasion to become alarmed simply because a woman with a fibroid of the uterus has become pregnant. Let nature alone and do not interfere until labor takes place and then be governed by the indications presented at the time.

THE PREVENTION OF SCARLATINAL NEPHRITIS.*

By Floy McEwen, M. D.,
Newark, N. J.

The development of a nephritis during the course of scarlet fever must always give us the greatest concern. It is one of the formidable complications of the disease. It may occur either as a complication or a sequel. As a complication it usually occurs from ten to thirty days after the subsidence of the rash. The acute exudative forms of nephritis belong to the second or third week of the disease. Most of these cases last about four weeks and terminate in recovery. There occurs, however, in the third week an acute diffuse nephritis. This form of nephritis is apt to persist and go on up to the time of the patient's death. Scarlatinal nephritis is probably far more frequent than is generally supposed. It is estimated by Dudley that out of 100 cases of scarlet fever, nephritis may be expected in 57. A diminution in the quantity of urine is usually the first symptom noted. An examination of the urine at this time will usually show the presence of albumin or the disease may set in suddenly with intense headache, suppression of urine, stupor or convulsions and such cases may be speedily followed by coma and death. As a sequel scarlatinal nephritis may not appear for several weeks after convalescence, so that no patient can be considered safe till five or six weeks have elapsed. There seems strong reason to believe that indiscretion in diet or too early exposure is responsible for many cases of the disease.

As aids in the prevention of scarlatinal nephritis we have the internal use of urotropin and bisulphite of soda and the management of the diet.

Urotropin—Widowitz (Arch. Pediatrics, April, 1904, p. 248) has never had a case of nephritis among his 102 scarlet fever

*Read at the 140th annual meeting of the Medical Society of New Jersey.

patients since he introduced the plan of giving urotropin as a preventive. He gives from $1\frac{1}{2}$ to $7\frac{1}{2}$ grains three times a day, according to age, during the first three days of the disease and again at the beginning of the third week for another three days.

Bisulphite of soda—For a number of years it has been the routine of many physicians of this city to give bisulphite of soda in scarlatina. The use of this drug in scarlet fever was originally suggested by Dr. Edgar Holden, of this city, some twenty years ago. Dr. Holden has never seen a complication in any case where it has been used, and this has been the experience of other physicians whom I have consulted. It is given in 3-10 drop doses, according to age, of a saturated aqueous solution, repeated every two hours throughout the day.

Management of the Diet—Equally important with the medicinal treatment is the management of the diet, which should consist solely of milk for the first three weeks. In the early days of the disease, while the fever is high, the milk should be weakened by the addition of plain boiled water and fresh lime water. Boiled milk three ounces, boiled water two ounces, fresh lime water $\frac{1}{2}$ ounce—for one feeding every three hours. Later, when the fever has remained steadily 100 or less, for 24 hours, the milk may be gradually strengthened, according to the plan formulated by Dr. Henry L. Coit. (Arch Pediatrics, May, 1902).

Boiled milk	3	4	5	6	$6\frac{1}{2}$
Boiled water	2	2	2	1	1
Fresh lime water.	$\frac{1}{2}$	$\frac{1}{2}$	$\frac{1}{2}$	$\frac{1}{2}$	0

$5\frac{1}{2}$	$6\frac{1}{2}$	$7\frac{1}{2}$	$7\frac{1}{2}$	$7\frac{1}{2}$
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For one feeding every three hours; advance a step in the series every second day, when fever remains 100 or less for twenty-four hours. In the fourth week the diet may be enlarged by the addition of sago, with pasteurized cream; mush, rice pudding, baked apple, apple sauce, orange juice, junket, stewed prunes, racahout, farina, corn-starch, arrow-root, crackers, Huntley & Palmer's dinner biscuits, milk toast and lemon jelly. In the fifth week fish, oysters and white meat of chicken should precede broths, eggs and red meats.

The urine should be examined frequently and the first appearance of albumin should be the signal for a return at once to an exclusive milk diet. Water is given freely throughout the disease. There seems to be considerable evidence that in an exclusive

milk diet for the first three weeks of the disease we have our best safeguard against a chronic productive nephritis. All of the milk should be sterilized.

Dr. David E. English, of Millburn.—The production of scarlet fever nephritis seems to me to be due to the elimination of toxins by the kidneys. The old practice of applying grease to the skin I suspect caused many of these cases, because it did not permit the toxins to be eliminated by the skin, and, therefore, threw a greater burden upon the kidneys. This practice is going out of style. The scales probably do not carry the infection. It is my own personal belief that the infection is from the nose and throat entirely. No greasy preparation should be applied to the skin. My custom is to use soap suds and alcohol and get from the skin all of the poison that I can. I suspect the application of grease to the skin is one of the most frequent causes of scarlatinal nephritis.

Dr. Frank W. Pinneo, of Newark.—*The time when albuminuria appears in scarlet fever should be considered. If it appears early, according to Dr. Delafield, it is an acute congestion or acute exudative nephritis and is followed by recovery; if albuminuria appears late in the disease, the third week or later, and continues through convalescence, it is an interstitial nephritis with its permanent damage and the prognosis is less favorable. The lesson to be learned in the prognosis and treatment is that we should safeguard the patient, especially during the latter part of convalescence, and prevent the damage to kidneys which is so familiar to us in the histories of nephritis, "I had scarlet fever — years ago."*

SOME INTERESTING CASES OF EXTRA UTERINE PREGNANCY.*

By Joseph S. Baer, M. D.,
Camden, N. J.

Few conditions that may at any time confront the general practitioner are of more importance than extra-uterine pregnancy. The imperative need of an immediate and positive diagnosis is well recognized, because in the majority of cases the life of the patient depends upon prompt surgical interference.

In this paper I have not discussed the subject in any way, being content simply to record the few cases annexed, as specimens of the various conditions that may arise. In these days of modern diagnosis and surgery the mortality ought to be small,—it is bound to be large under an expectant treatment. My experience covers more than twenty cases, three of which died, mainly because of failure of diagnosis, and

*Read before the Camden County Medical Society, October, 1905.

delay. In the cases treated by vaginal incision there were no deaths.

CASE I. Mrs. Anna M. P., of Canton, N. J., age thirty-one, was brought to Cooper Hospital March 28, 1902, with the following history: Puberty occurred at fifteen; normal in character. One child two years previous, instrumentally delivered, with puerperium normal. She was in good health and menstruated regularly until May 22, 1901, when amenorrhoea occurred and continued for about two months, the patient believing herself pregnant. At this time she was seized with a sharp lancinating pain in the left iliac region, with fainting, pallor, uterine hemorrhage and the passing of some shreds of membrane. She was confined to her bed for some days, with disappearance of all symptoms, and went on believing herself normally pregnant. According to her calculation she should have been confined about February 22, 1902. On the night of March 27, she was taken with violent abdominal pain, different, as she stated, from regular labor pains. The family physician, after examination, being unable to find the os uteri and recognizing the abnormal condition, brought her to the hospital.

The patient was rather pale and had an anxious, worried expression. Upon examination the abdomen was found to be rather larger than normal, and did not present the ovoidal appearance of a normal pregnancy, but instead, there was a marked bulging on the left side. The uterus could be felt pushed over and upward to the right, and of about the size of a two months' pregnancy. On the left side the foetal members could be felt distinctly, with a stethoscope the foetal heart sounds were clearly heard. Per vagina the cervix was found to be pushed upward and to the right, flattened against the pubic bone by the foetal head, which occupied the pelvis in the first position. The cervix, by the way, was divided by a septum extending to the fundus. Immediate operation was decided upon, for the reason that the child being alive, it was feared that labor pains would set in and cause its death. When the patient was under ether, I decided that the child could be delivered safely through the vagina by making an incision through the posterior vault. Several of my colleagues present disagreed with this view and thought I should operate through the abdomen.

To be sure of my ground, I made a short median incision through the abdomen, which

was immediately closed, because the condition seemed too formidable to deal with from above. The omentum covered the sac, with blood vessels in every direction, almost the size of one's finger, so that the danger of causing uncontrollable hemorrhage appeared to me to be so great that I decided to treat the case through the vagina. An incision was made through the posterior vault, a little to the left of the median line, large enough to apply the forceps, the membrane ruptured and, as rapidly as possible, a male child was delivered, crying lustily when the head emerged from the vulvar orifice. The child, weighing about seven pounds, was a "blue baby" and lived only twenty-four hours. There was no hemorrhage, and no attempt was made to dislodge the placenta, which was found to be attached to the posterior portion of the broad ligament and pelvis and the mesentery of the surrounding intestines. The cord was tied as high as possible and severed. The cavity and vagina were packed, and the patient returned to bed without shock. Twenty-four hours later the temperature reached $105\frac{3}{4}^{\circ}$, dropping to 100° the next morning. On the twenty-sixth day the temperature became normal and remained so until she left the hospital on the forty-fourth day. On the fourth day, part of the packing was removed, and on the fifth day, all of the gauze was withdrawn, followed by irrigation and repacking. On the seventh day, a portion of the placenta presenting, an attempt was made to remove it, but an alarming hemorrhage ensuing, the cavity was rapidly repacked, and the placenta was removed in portions at intervals as was deemed safe.

Two years later I saw this patient, who had gained forty pounds, and was the picture of health. The attachment of the ovum was evidently near the fimbriated extremity of the tube, and as it became too large for its situation, slipped out into the pelvic cavity and formed an attachment to the surrounding tissues for nourishment, and went on to term,—a so-called tubal abortion. My reasons for approaching this case below were, that I believed, the head being in the pelvis, a living child could be delivered, through a vaginal incision, by the forceps, and the drainage would be downward and not upward, also there would be better control of the hemorrhage by packing, should the placenta become detached. I believe, had the operation been done from above, that the patient would have died. At

this time I thought that this method of treating a case of this kind was entirely original; in Thomas' "Diseases of Women," I found an account of a similar case, treated by Dr. King, and without ether, on Edisto Island, off the coast of South Carolina, in 1816, saving both the mother and the child.

CASE 2. This case I saw through the courtesy of Dr. R. I. Haines, who deserves credit for his promptness in recognizing the condition. Early on the morning of May 8, 1901, I was called to see Mrs. M. L., aged twenty-nine, who gave the following history: Puberty occurred at thirteen years, accompanied by dysmenorrhoea. Two children; first, four years ago; second, two years ago; labors and puerperium normal; no miscarriages; menstruation regular, but with pain in hypogastrium, most severe on left side, radiating to thigh and knee. Slight mucous leucorrhoea. Aside from menstrual pain she continued in good health until March 20, 1901, when she missed her period. About April 20 she began to suffer from morning nausea and vomiting. On May 4th, while cleaning house, pulling and lifting heavy articles of furniture, she was seized with a sharp lancinating pain in the left groin, compelling her to go to bed, but by the next day this had passed away. On the following day she had a less severe attack. On the morning of the 8th she went into the yard and was found lying upon the ground in collapse. She was carried indoors and Dr. Haines called. The first attack was accompanied with uterine bleeding and the passing of decidual shreds. When I reached the house the patient was practically pulseless, colorless and suffering from air hunger, with sub-normal temperature. Concurring with the diagnosis of ruptured extra-uterine pregnancy, I advised immediate operation.

Valuable time was lost in seeking the husband to get his consent, so that the patient did not reach the hospital till afternoon. No stimulation was allowed except heat to the body and elevation of foot of the bed. Upon making a median incision to the peritoneum, it was noticed bulging through the wound. Puncturing it, the blood spurted two or three inches above the abdomen. Rapidly enlarging the incision, my fingers sought the left tube and found a rupture in the superior aspect of the middle third. Grasping the bleeding point, I ordered stimulation by hypodermic injection of strychnine, hypodermoclysis, enemata of

strong coffee and whiskey. While this was being done, I rapidly ligated the tube and ovary and removed them. The clots were removed and the cavity irrigated with normal salt solution and sponged.

While placing the abdominal sutures, I noticed some blood welling up from the back of the uterus. After examination of the pedicle, the ligature being intact, the patient was placed in the Trendelenburg posture, and withdrawing the intestines from Douglas' pouch free oozing was noticed from the bottom of the pelvis, where some adhesions had been broken up. The bleeding had not occurred earlier because the vessels were practically empty, but by this time enough salt solution had been absorbed to cause the oozing. The patient being almost moribund, I did not attempt to search for the vessels and ligate, but packed gauze firmly upon the bleeding point with a rubber drainage tube along side and closed the wound. The pulse was scarcely perceptible and intra-venous infusion of salt solution was ordered, with heat to the body and bandaging of the limbs. After a pint of the solution had entered the vein the pulse was 140, and by the time a quart had entered, it dropped to 120. Hypodermoclysis was used for several days. The pulse varied between 120 and 140; on the sixth day dropped to 100. On the third day the temperature rose to 102 for a few hours, then remained about 100, and the patient left the hospital on the twenty-fifth day. She has since born a child with normal labor, and is perfectly well to-day.

CASE 3. Mrs. E. R., aged twenty-nine. This patient was sent to the hospital April 21, 1899, with a diagnosis of pelvic abscess. She was very deaf and very dull and apathetic, so much so that a satisfactory account of the case could not be obtained, none of her friends then present being able to give us much information. The following history being mostly obtained after convalescence: Menstruation began at sixteen. Had always suffered from dysmenorrhoea. One child seven years of age; labor instrumental; puerperium normal. No abortions. Twelve years ago, while roller skating, had a fall which was followed by a vulvovaginal abscess; three months later another occurred upon the opposite side, which ruptured spontaneously; since birth of child has had pain, more or less, in the pelvis. For the last four years her pain has been growing more severe each year, one attack of pelvic inflammation confining her to bed.

Previous to entering the hospital had been in bed six weeks. Complained of pain in the lower abdomen and pelvis with a sense of fullness and weight upon the rectum. She was very weak, anemic and seemed to be in a chronic septic condition. I should have said that she claimed to be a widow and that she had menstruated regularly. Upon examination the abdomen was found to be tympanic. Per vagina a fluctuating mass was found bulging almost to the vulvar orifice, pushing the uterus upward and to the right.

An incision was made close to the uterus posteriorly, disclosing a foetus of about three months' gestation, followed by a quantity of amniotic fluid. The slight manipulation I made with my finger in the cavity was followed by an alarming hemorrhage. Quickly packing it with gauze controlled the bleeding. I immediately made a median abdominal incision, and found the left pelvis filled with a large mass composed of blood clots, omentum, tube and ovary and placental tissue. The ovum had evidently slipped out of the ruptured tube and formed a new attachment, as the foetus appeared to be healthy, and the discharge of amniotic fluid indicated that the membrane had not been ruptured. The adhesions were rapidly broken up and the mass ligated and removed. The mass contained considerable healthy looking placental tissue. There were a number of dark blood clots within the folds of the intestine, which were removed and the cavity flushed with salt solution. There was no active bleeding but very free oozing from the site of the placenta and denuded surfaces, which was controlled by gauze packing, a strip being passed through the opening in the vaginal vault, the balance being rather firmly packed upon that in the pelvis. A rubber drainage tube was also passed through into the vagina, one end allowed to protrude through the abdomen making through and through drainage. The incision was closed and the patient returned to bed with a pulse of 110; temperature 98°. The temperature once reached 102 $\frac{3}{5}$ ° for a few hours but most of the time remained about 100°. Aside from a prolonged convalescence, the patient made a good recovery and has been well ever since. After the operation a man called to inquire after the patient. He gave me a history of suppressed menstruation, and said that about six weeks previously, while returning from shopping in Philadelphia, she was taken with a sharp pain in the left side, and could scarcely reach home.

She felt a desire to go to the yard and they found her there in collapse and brought her in. The patient herself afterwards acknowledged that she was married and had missed several periods.

CASE 4. Mrs. W. F. J., a negress, aged twenty-six, was sent to the hospital November 11, 1905, as a case of incomplete abortion. The following history was obtained: Family history, negative. Personal history: Had ordinary diseases of childhood, also pneumonia, erysipelas and influenza. Puberty at fifteen, normal. One child ten years ago. Labor normal, puerperium normal; no abortions; menses regular, in time lasting three days. About five weeks ago was seized with moderate lancinating pain in the left side. Two days later the patient had a return of the pain on the same side, very severe, which she states was tearing in character, accompanied by syncope, coldness of extremities, free perspiration and great weakness. From this time to admission to the hospital, there was constant and moderately severe sharp pain radiating to the left leg. Temperature 99°, pulse 84. Upon examination, the vulvar orifice was relaxed, vagina shortened. The cervix was flattened against the pubes; body of uterus deflected to the right. The pelvic cavity was filled by a mass which gave an indistinct sense of fluctuation. A cystic mass was felt through the abdomen extending to a finger's breadth above the umbilicus, which disappeared when a catheter was introduced, and seventy-six ounces of urine had been withdrawn. The pelvic tumor could then be felt above the brim.

It was supposed that the condition might have been an abortion with infection and the development of a pelvic abscess. It was decided to curette the uterus and make a diagnosis under ether. The following day the patient was etherized and after curettement a small trocar and canula introduced into the mass producing a flow of fluid blood. An incision was made through the posterior vault, the fingers introduced, breaking up a large firm mass of clotted blood. There were two separate bulging pockets within the cavity which were broken into and clotted blood turned out, and the cavity irrigated with several gallons of salt solution. There was considerable free oozing which was controlled by gauze packing, a rubber drainage tube introduced, and fastened to the edge of the incision with a catgut suture. The patient made smooth recovery.

CASE 5. Mrs. R. C. W., aged twenty-one years, was admitted to Cooper Hospital, November 11, 1905, giving the following history: Menstruation began at thirteen, normally. She has had three children; first, three years ago; second, one and a half years ago. Labors and puerperium normal. Three abortions, four and one-half years ago; no infection followed. Present sickness began six weeks ago by what the patient thought was an abortion. She had a slight show two weeks previous, and with this exception had not had menstruation for four months. She thought she was pregnant but noticed no abnormal enlargement, and did not feel as she had in former pregnancies. Six weeks ago she was seized with cramp-like pains in the back and abdomen. She did not, however, refer the pain to any one point. This increased in severity and about six hours later a vaginal discharge of blood occurred, small in amount, containing a substance that was supposed to be membrane of the foetal sac. The pain subsided, but, after two days, returned with great severity, suddenly she became very weak, suffered from vertigo and felt as though she would faint; her extremities were cold and she perspired freely. The pain was located in the lower abdomen and not confined to either side. About four days later it became localized in the left side. On admission she still complained of pain, her temperature was 99° and her pulse 134.

Upon examination, a mass as large as a coconut was found to the left pushing the uterus, which was somewhat enlarged, to the right. On the following day her temperature was normal, pulse 88, of good volume. After obtaining the above history it was decided that the patient had a pelvic hematocele, due to a ruptured tubal pregnancy. Her condition remaining good, and repeated examinations showing a rapid decrease in the size of the mass, it was considered that it would be absorbed and that an operation would not be necessary. She left the hospital two weeks later with a decrease of more than half in the size of the tumor.

The second case demonstrates that most of these cases can be saved by a prompt recognition of the condition and the early resort to operative measures. Cases three and four illustrate the difficulty of diagnosis where a correct history cannot be obtained. The main point of difference between pelvic abscess and hematocele is the temperature record. The temperature in hematocele, in my experience, never running above

99° to 100°, while that in pus cases is higher. I have, however, evacuated large collections of pus in the pelvis with a temperature of 99° to 100°. Case five is an instance of what nature will do for some unfortunate women. Several cases of this character have come under my observation. The mass, of course, does not undergo infection or the outcome would not be so favorable.

Another paper would have appeared in this issue but delay in returning proof has prevented. —Editor.

Reports from the Counties.

BURLINGTON COUNTY,

Dr. George T. Tracy, Secretary.

The regular quarterly meeting of the Burlington County Medical Society was held at the Arcade Hotel in Mt. Holly, on October 10th, 1906. There were twenty-five members present. Dr. Lyman Hollingshead, of Pemberton, made application for membership. The committee appointed to investigate lodge and contract practice in the county reported progress and presented an agreement which has been signed by a majority of the members. The agreement is as follows: "Believing it to be for the best interests of the medical profession, and in keeping with the same; We, the undersigned, agree not to attend any corporate body, or association of men or women, for any fixed charge or sum that is less than we would charge a single individual, who might not be a member of any such body or association." This became a fruitful source for discussion and an endeavor was made to determine the status of the railroad surgeon, and whether he received full compensation for services rendered.

Dr. E. S. Adams, chairman of the section on Obstetrics, announced the following program for the day:

Symposium on Obstetrics and Gynecology: "Dystocia Due to Placenta Praevia," Dr. Irene D. Young; "Venereal Disease of Female Generative Organs," Dr. J. E. Dubell; "The Care of Premature Infants," Dr. E. S. Adams.

Many interesting experiences were elicited in the discussion which followed by many of the members. A committee was appointed to arrange a suitable time and place for the next annual meeting and after the regular business to provide for the entertainment of the members' wives or guests at a social session and dinner.

The society here adjourned to dinner, the quality, quantity and service of which were to the complete satisfaction of all who participated. The "post prandial" service was as follows: "Medical Legislation," Dr. L. M. Halsey; "The Ideal Health Officer," Dr. Alex. Marcy, Jr.; "The County Physician to Replace the Coroner System," Dr. J. D. Janney; "Useful Preparations of National Formulary," H. P. Thorn, Ph. G. and E. B. Jones, Ph. G.

HUDSON COUNTY.

A. A. Strasser, M. D., Reporter.

Under the presidency of Dr. Gray, the Hudson County Medical Society began its year's work by the attendance of a goodly number of members and the presentation of excellent scientific work, besides embarking on the wave of that movement that received its impetus from the American Medical Association, namely, to attempt to influence and teach the lay public hygienic and sanitary truths and thus merit the title of doctor in its etymological sense.

A number of exceedingly interesting and instructive clinical cases were reported. Dr. G. K. Dickinson reported a case similar to the one he knew that Dr. Haskings was about to report. A woman of 70 years had daily vomiting, expelling once or oftener the entire contents of the stomach, and other classical symptoms showed it to be a case of dilatation of the stomach. For three months lavage was practiced with some improvement. Then she developed an ill-defined gallstone colic with jaundice of a mild type. This was again relieved by laxatives and lavage, but an exploratory celiotomy was advised and accepted. The gallbladder was small, and in its distal end had several gallstones; its tip was fastened, however, to the stomach, in the region of the pylorus, by a band about the thickness of an ordinary lead pencil. This band pulling on the pyloric end of the stomach had caused the gastric dilatation. The band was separated, the gallbladder and stones removed and patient recovered. Dr. Faison reported three interesting cases; two of gastric ulcer, one of which had been pronounced malignant three years before; the other had been fed rectally for six weeks (!) and at the time of operation it was doubtful whether such was justifiable, as she was passing only three and one-half ounces of urine in twenty-four hours. Both were treated by posterior gastroenterostomy, suture method; made a good recovery and gained in weight. The other case was one in which in August, 1906, he removed a Murphy button which he had placed in August, 1905. There had been symptoms pointing toward bowel obstruction. The bowel above the button was enormously distended. The intestinal wall was still clamped in the jaws of the button; but there was ulceration just beyond it. Dr. Hasking's case was one of a lesson taught by post-mortem examination. A woman who had suffered from pulmonary tuberculosis for two years, developed during that time an attack of appendicitis, from which she apparently recovered under medical treatment. But she developed vomiting of a pernicious character, which finally led to her death. Autopsy revealed the following condition: Tubercular peritonitis; appendix found sloughed off in a mass of adhesions, leaving a proximal stump of 0.5 cm.; on opening the intestine for 25 cm. from ileocaecal valve there were numerous ulcers, probably tubercular. The omentum was excessively large, extending down below pubis, even into true pelvis. It was attached intimately to the appendix, one thick band extending from the appendix to the pyloric end of stomach and pulling the axis of that organ almost vertical. The case illustrated another point. Orth claims that he has never seen gastric tuberculosis; so in this case while miliary tubercles studded every part of the abdominal cavity, the peritoneum over the stomach was perfectly free of them.

Dr. Lambert reported a case of purpura rheumatica of a fatal type. A three-year-old boy when first seen had pains in ankles and knees, and a small spot of purpuric extravasation on the calf of one leg. His temperature was 101° F. rectally; throat and heart without lesion. The purpuric eruption spread, involving the whole body below pelvic line. Exitus lethalis. Dr. Strasser reported a case of mumps in a young man of twenty-two years, involving both sides of the face and complicated by a rightsided epididymitis, that went on to an orchitis later. Spontaneous recovery. The unusual feature was the epididymitis preceding the orchitis; for it is the testicle and not the epididymitis that is usually involved. Dr. Parsons prefaced his remarks on diabetes by the statement that he had spent much thought on diabetes mellitus but was very conservative in establishing its existence or non-existence from a single test of the urine. Two cases emphasized this fact for him. In the first a man of about 30 years of age came with the symptom complex, pointing toward a diabetes mellitus. Urine examination corroborated the diagnosis. Restricted diet diminished the amount of sugar and finally the patient, on visiting another physician, who failed to find any glycosuria, left him for good. Later another case presented itself, and repeated and frequent examinations revealed the fact that in this case he had to deal with an intermittent or perhaps dietary glycosuria. He was guarded in his diagnosis, and examinations extending over quite a period established the fact that the diabetes was intermittent. Patient is now perfectly well. Dr. G. E. McLaughlin, in commenting on this case, related that it was possible in one of his cases to demonstrate, that no matter how mixed or how rich in carbohydrates the diet, it was only after partaking of canned pears that his case showed an alimentary glycosuria.

Dr. Thos. McLoughlin reported a case of osteomyelitis of the femur, treated for several months as rheumatism; he drew the differential picture of the two affections and spoke of the treatment and complications of osteomyelitis. Dr. Spencer related the history of a case of progressive anaemia of eighteen months duration. Patient's family and personal history were negative; habits good, suffered only from constipation. Examination of the blood showed only a simple anaemia. Iron, arsenic, forced feeding, milk diet, all had no effect; neither was he benefited by a trip to the country. While there he developed a severe diarrhoea, which persisted on his return home. Acting on the hypothesis that there was some pancreatic derangement, extract of pancreas was given with not only a cessation of the diarrhoea but also a marked improvement of his general condition. There had been no fatty stools.

Dr. Rosenkrans also reported several cases of diabetes, which he had treated according to the dietary formulæ advised by Von Noorden in his lectures in New York last year. He felt too that many patients were outrightly starved by a too restricted dietary. Dr. Blanchard related a case of cholelithiasis of several years' standing, who had refused operation before, but finally consented. After celiotomy, even most careful search failed to reveal any gallbladder or cystic duct. This led Dr. Vreeland to suggest that perhaps the woman was a parrot, as parrots and horses, he knew, had no gallbladder. In commenting on Dr. Blanchard's case, Dr. Dickinson said he had seen the gallbladder imbedded deeply in the liver tissue

and after incision of the liver was able to excise both it and the contained stones. The president, Dr. Gray, also reported a case of intermittent alimentary glycosuria that for three years had from one-half to two per cent. of sugar in urine after a full meal, but who now for the past eight years has been entirely free of any glycosuric symptoms. He, too, had had difficulty in one case on finding a very much contracted gall-bladder, which was enclosed in a mass of adhesions. This and the fact of tense abdominal muscles, which would not relax in the deepest anaesthesia, caused him to drain instead of doing a complete cholecystectomy.

This series of cases was followed by the reading of the papers of the evening, which, to conform with the by-laws, were on the subject of sanitation and public health. Dr. Dickinson's paper on the "Sanitary Control of Tuberculosis, especially on the Dissemination of Tuberculosis," was read.* Dr. G. E. McLaughlin had invited Prof. Sedgewick, who was detained by stress of business from attending, to address the Society on general sanitation. Prof. Sedgewick sent some of his pamphlets from which Dr. McLaughlin had prepared the paper.* In the discussion, Drs. Vreeland, Rosenkrans, Rector, Haskings, Sheiner, Blanchard, McLaughlin, Lambert, of the Jersey City Health Board; Spence, Gray and Dickinson participated. Dr. Vreeland pointed out that in reality our present method of treatment, the oldest method was simply an example of the unpremeditated experiment of which Prof. Sedgewick wrote. Dr. Rector pointed out the necessity of a set of rules in plain terms, issued and distributed by and stamped with the authority of the Board of Health; it was as important as the strict enforcement of the reports of physician to such boards, so that such rules might be uniform throughout the country. Dr. Sheiner related how he had investigated for himself the way the county provided for indigent consumptives at Snake Hill. Not only was there no attempt at isolation but no care of the habits of these patients was taken. Dr. McLaughlin said that the control of tuberculosis resolved itself into the control of the sputum. He agreed that not only were circulars as suggested necessary, but so were street signs and a hospital for tuberculosis patients. In answer to this Dr. Lambert said that not only were the circulars but also street signs already under consideration of the Board and that their early issue is contemplated.

Dr. Dickinson in summing up said that the whole matter is one of education of the public and physicians, by liberality with circulars, public lectures, use of the press, support of the traveling tuberculosis exhibit and of the Anti-tuberculosis League. District nursing and its value were as yet underestimated. He divided the cases of tuberculosis into three classes. First the poor and practically moribund, sent to the hospital to die; this is the right place for them; they can at least die comfortably; second those that should have sanatorium treatment; this class is usually taken in the early stages and from unsanitary homes to be taught how to protect others and themselves, as well as go on to cure; the third class is so situated it does not need to leave home and can be educated there. On motion by Dr. Rosenkrans it was decided to have a committee appointed to draw up circulars to be printed in a number of languages for free distribution

to physicians, containing in concise but plain terms rules of conduct in tuberculosis.

After some other general remarks on the need of a Board of Health laboratory, a chemist, authorized inspectors; the need for individual effort on the part of members in sanitary matters, the use of the public lay press, legal aid of the health board, and control of the soft coal smoke nuisance, the meeting adjourned, and a collation was served.

*The papers referred to will be printed in a subsequent issue of THE JOURNAL.

MERCER COUNTY,

C. H. Mitchell, M. D., Reporter.

The regular meeting of the Mercer County Medical Society was held October 9, 1906, at Trenton, N. J., and during the evening considerable discussion arose among those present regarding that bug-bear of the profession—contract practice. The members of this society have very little use for physicians indulging in any form of contract work and they want to rid the society and city, if possible, of those who cannot make sufficient to exist without injuring their fellow practitioners by this cheap method of selling their knowledge.

It appears to members of this society that graduate physicians who cannot command more than ten or fifteen cents per call, which many of their contracts net them, are certainly hardly the kind of material they want in their medical society or classed among their acquaintances, and they are after such practitioners and will not be satisfied until such cheap elements reach their proper level, which would probably be shining shoes or acting as fish mongers. We don't intend to consult with these fellows or have any connections with them whatever, and we sincerely hope the other societies will follow suit.

The system practiced by the minion of the railroad companies, namely, the railroad surgeon, in serving a millionaire corporation for practically nothing more than the privilege of doing so, was also thoroughly discussed by various members, especially those who are yearly being deprived of a number of valuable cases as a result of his actions, they therefore feel that a physician, who has the interest of his profession so little at heart as to donate \$5,000 worth of services for \$500 worth of compensation, certainly is not a valuable member to his society, or proper associate for his brother practitioners, and should be dealt with the same as all physicians who engage in contract practice.

MIDDLESEX COUNTY.

Alfred L. Ellis, M. D., Secretary.

The quarterly meeting of the Middlesex County Society was held at the Hillside Inn, Metuchen, October 17th, with a large attendance of members. Dr. H. H. Janeway, the President, in the chair. Two new members were elected and two others were proposed, but their credentials not being at hand, action was deferred. Reports of committees were received and considerable discussion was held thereon. A communication was received from Dr. Clark, the Councilor for this district, in reference to contract practice, insurance examiners' fees, Dr. McCormick's visit to New Jersey, etc. Several members participated in earnest discussions on contract practice and insurance fees. On the former action was deferred for information and deliberate considera-

tion, the general consensus of opinion being that it was a broader subject than at first appeared, that the question of contract was involved in much of the physician's and surgeon's business, and its justification is to be determined very largely by the question as to whether an adequate amount is received for the services rendered. In the matter of the insurance fee, the action of the State Society was endorsed by a unanimous vote. The question of making one of the quarterly meetings a public meeting to which prominent professional and business men should be invited, when questions of public interest shall be discussed—questions on which the judgment of medical men ought to be heard and weighed, elicited much discussion, and was finally referred to the committee of arrangements for the next quarterly meeting, with power to determine for that meeting. It was resolved that the next meeting—in January—be held at such time and place as will suit Dr. McCormick, of Kentucky, who, by a unanimous vote, was invited to attend and address the Society.

After adjournment the members, on invitation of the physicians of Metuchen, partook of an excellent and bountiful dinner at the Hillside Inn.

MORRIS COUNTY,

H. W. Kice, M. D., Secretary, Wharton.

The Morris County Medical Society met at Chatham September 11th, Dr. W. J. Wolfe, the president, in the chair. Dr. Theodore W. Corwin, of Newark, gave a very practical lecture and demonstration on the deviation of the septum. The subject was treated in a thorough manner, giving pathological condition, and treatment, discussing the various operative procedures, of which he preferred the submucous. A patient upon whom the doctor had recently operated was presented before the society. Dr. Thomas P. Prout, of Summit, read an excellent paper on the subject of Neurasthenia. It is certainly worthy of publication in *THE JOURNAL*, and I forward it herewith. I send also an item from the *Dover Index*, giving an account of the organization of The Physicians' Association of Dover and vicinity. The county society will hold its next meeting in Dover on the second Tuesday in December.

The Physicians' Association.—The practicing physicians of Dover, Rockaway, Wharton, Succasunna and Mt. Arlington have succeeded in completing what is known as the "Physicians' Association of Dover and Vicinity," by electing the following officers at a meeting held last Friday evening:

President, Dr. I. W. Conduct, Dover; vice-president, Dr. F. W. Flagge, Rockaway; secretary and treasurer, Dr. J. W. Farrow, of Dover. The object of this organization is to establish a uniform rate, the present rate to be increased somewhat so as to conform with the prices received by physicians in other towns.

More than this, the organization will have a tendency to do away with the "dead beats" who have been playing havoc with the physicians in this section of late. Any person who calls upon a physician, if a stranger, will be asked who has been their physician heretofore. The next question will be "Do you owe that doctor anything?" If they do owe another doctor, the one upon whom they call will be unable, according to the rules of the new organization, to administer treatment to them in any way until they have "squared" the bill. They will also have an "information list,"

more practically called a "dead beat" list. So people who are disposed to be dishonest had better maintain good health or change their tactics.

Later the physicians will probably ask the town officials to fit up a few rooms to be used as a hospital, and some of them will devote some time each day, gratis, in caring for unfortunate suffering people. The new association will also tend to create a more friendly and sociable feeling among the doctors.—*Dover Index*.

MORRIS-SUSSEX-WARREN.

The eighth annual meeting of the Tri-County Medical Association of Morris, Sussex and Warren counties was held in the parlors of the Newton Club, Newton, N. J., on October 9, the president, H. D. Van Gaasbeek, M. D., in the chair, who opened the meeting with a few remarks. The annual address was delivered by Algernon T. Bristow, M. D., clinical professor of surgery, L. I. College Hospital, on "Two Cases of Extra-Uterine Pregnancy, occurring in the same Individual at Five Months' Interval." It was an able paper, and I forward it for publication in *THE JOURNAL*. A paper on "Evolution of Therapeutics" was read by Alvah C. Van Syckle, M. D., of Hackettstown, and an "Exhibition of Specimens" by Joseph H. Hunt, M. D., of Newton. The specimens were gathered from Indian tribes, illustrating the superstitions of their "medicine men;" Indian rattles, eagle's head and tom toms; also scorpions and turtles, in dried state, used by them as medicine; also a collection of precious stones, mostly in the rough state, with history of the same by the doctor. Dr. Van Gaasbeek also exhibited a specimen of a double foetus, which was delivered at 5½ months. It was perfectly formed. Both being males, joined at the thorax—"Thorocopagus." The meeting was a very pleasant and profitable one, the discussions being participated in by Dr. P. A. Harris, of Paterson, and Dr. Chase, of Brooklyn, N. Y.

The following officers were elected for the ensuing year: President, Alfred A. Lewis, M. D., of Morristown; first vice-president, Alvah C. Van Syckle, M. D., of Hackettstown; second vice-president, J. B. Pellet, M. D., of Hamburg; treasurer, F. W. Flagge, M. D., of Rockaway; secretary, C. B. Smith, M. D., of Washington. Executive Board—with the above officers—Drs. Bruno Hood, Calvin Anderson and L. C. Osmun.

After adjournment the society repaired to the Cochran House, where an excellent and bountiful dinner was served.

H. D. V. G.

OCEAN COUNTY.

William G. Schauffler, M. D., Reporter.

The annual meeting of the Ocean County Medical Society was held on October 25th at the house of the retiring President, Dr. I. H. Hance, in Lakewood. The following officers were elected for the ensuing year: President, Dr. R. R. Jones, Toms River; Vice-President, Dr. V. M. Disbrow, Lakewood; Secretary, Dr. A. M. Heron, Lakewood; Treasurer, Dr. Harold Pittis, Lakewood; Annual Delegate, Dr. R. L. Disbrow, Toms River; Reporter, Dr. W. G. Schauffler, Lakewood. The Treasurer's report showed a good balance in the treasury, with all bills paid. Dr. Otto C. Thompson, a graduate of the College of Physicians and Surgeons, Baltimore, Md., of the class of 1906, who has just settled in Cassville, N. J., was elected a member, making fifteen active members in the Society.

Camden County Medical Society Honors One of Its Oldest and Most Faithful Members

H. Genet Taylor, M. D.

The members of the Camden County Medical Society, with many invited guests, assembled at the Dispensary Building in Camden, October 9, 1906, to pay fitting honor to the Society's honored guest, Dr. H. Genet Taylor. One of the oldest and most beloved practitioners in the city, Dr. Taylor had full reason to be proud of the encomiums passed on his brilliant career in his chosen profession. Every inch a gentleman, he has held that position among his fellows that is enviable and which only those who make a good effort at following the Golden Rule ever need hope to attain.

The name and career of the honored guest was

how far the influence of any amiable, honest-hearted, duty-doing man flies out into the world; but it is very possible to know how it has touched one's self in going by."—Dickens.

In addition to these, the following invited guests paid eloquent tributes to the life and service of Dr. Taylor: Drs. Alexander Marcy, Jr., President, and W. J. Chandler, Secretary of the Medical Society of New Jersey, and Dr. D. C. English, an ex-president of the State Society and editor of their JOURNAL.

All of these kind sentiments were responded to by Dr. Taylor, who was deeply moved by the praises sung in his honor.

The committee which arranged the meeting and the banquet which followed consisted of Dr. Daniel Strock, Dr. Howard F. Palm and Dr. E. A. Y. Schellenger.



H. GENET TAYLOR, M. D.

toasted by those who knew him best. The springs from which coursed their eloquence were found in quotations of the men who flourished in the Golden Age of English Literature—of Tennyson and Dickens and the poet of American poets, Henry Wadsworth Longfellow.

The toasts of the various speakers can best be summed up in the quotations given, as follows:

Dr. E. L. B. Godfrey—"You are a public character, and live in all men's thoughts most deservedly."—Dickens.

Dr. John R. Stevenson—"Fame only comes when deserved, and then it is as inevitable as destiny, for it is destiny."—Longfellow.

Dr. Alexander Marcy, Sr.—"He bore without abuse the grand old name of gentleman."—Tennyson.

Dr. William H. Iszard—"He did in the general bosom reign, of young, of old."—Shakespeare.

Dr. Daniel Strock—"It is not possible to know

MENU.

Oyster Cocktail	
Green Turtle Soup	
Appolinaris	Sauterne
Olives	Celery
Fried Halibut	Tomato Sauce
Tenderloin of Beef	Mushroom Sauce
Potato Croquettes	
Taylor Punch	
Lobster Newburgh	
Chicken Salad	
Ice Cream	Cakes
Coffee	Cigars

DR. GODFREY'S ADDRESS.

In response to the toast, Dr. E. L. B. Godfrey spoke as follows:

"I arise, Mr. President, through your invitation, to the performance of a very pleasant duty, to respond to the toast, 'The Health and Prosperity of Our Honored Guest,' Dr. H. Genet Tay-

lor. This response is not intended as either an epitaph or 'taffy,' but as the simple record of a physician with an exemplary career of forty-six years in the practice of medicine, whom you have chosen this day to honor. It is not strange, Mr. President, that this signal honor should be accorded to our guest, since he was nurtured from the cradle in the noble profession which he so markedly adorns. His father was an eminent physician, closely identified with the development of the State and County Medical Societies and the organization of the City Dispensary. By inheritance, therefore, our 'Guest of Honor' received a rich legacy of professional pride which has been an inspiration to his life.

Dr. Taylor was graduated from the University of Pennsylvania in 1860. What a valuable possession it is to hold a diploma from an Alma Mater so illustrious and renowned! I speak of the Alma Mater of our guest with pride and satisfaction because during the last twelve years there has not been an applicant from this university, for the medical license of New Jersey, who has been refused admission to our State examinations or rejected after admission. At the time of graduation of our 'Guest of Honor,' in 1860, the North and South were on the eve of a civil conflict which, in many respects, stands without a peer or a parallel in the history of the world. The whole country trembled with excitement and anxiety. Secession and slavery were the issues of the day. From both North and South the young men of the country rushed into the conflict and imperilled all in the defense of the cause for which they contended. Our guest, with other surgeons, was invited by Surgeon General Henry H. Smith, of Pennsylvania, to go to Washington to attend the wounded brought in from the field of Bull Run, the first battle of the Civil War. After discharging this duty he was commissioned by Governor Olden, of this State, as first lieutenant and assistant surgeon of the Eighth Regiment, N. J. V., an honor sought by many influential surgeons older than our guest, who, at this time, was but twenty-three years of age. The Eighth Regiment was assigned to the famous Second Regiment of New Jersey and participated in the historic battles of the Peninsula under General McClellan.

"Those of you who have stood in the presence of General McClellan and have taken his hand, will recall his magnificent personality and his magnetic charm. Schooled in the use of heavy artillery through his personal observations in the Crimean War, and fresh from his victories in West Virginia, great results were expected from the general who had shown so much originality and tactical skill in organizing the army into corps as fighting units, instead of brigades, which were formerly the units of organization.

"You will remember that General McClellan chose the Peninsula between the York and the James rivers, with Fortress Monroe as the base of supplies, for his operations against the army of Virginia in front of Richmond. When, through victorious battles, he reached Seven Pines, within sight of the spires of the Confederate capitol and the capture of Richmond seemed assured, both flanks of his army were turned and he deemed it necessary to withdraw the center and to beat a retreat, almost precipitous, before the advancing forces of the Confederates. Our guest participated in all the battles of the Peninsula campaign—Yorktown, Williamsburg, Fair

Oaks, Malvern Hill, Seven Pines and other general engagements—and perhaps there has never been a time in his history when he moved with greater celerity than in the retreat of the army from Seven Pines. At Fair Oaks, his services were so conspicuous that he was personally complimented on the field by the commandant of the Second Brigade, Colonel Starr.

"The campaign of General McClellan was a failure, his army was withdrawn by Executive order from the Peninsula to cover Washington and confront the Army of Virginia north of Richmond, and General McClellan was superseded by General Pope. Our guest participated in the engagements of General Pope and, at the second battle of Bull Run, he, with other surgeons, volunteered his services to go into the Confederate lines to attend the wounded Union prisoners. General Pope retreating at this time, our guest was detained within the Confederate lines for ten days. The campaign of General Pope was not successful and General McClellan was reinstated in command of the Army of the Potomac. The invasion of Maryland followed and General McClellan met General Lee in deadly combat at Antietam and drove him back into Virginia with great loss. Our guest participated in the battle of Antietam and rendered active and prolonged service in caring for the wounded.

"The failure of General McClellan to follow up his advantage in the retreat of General Lee from Antietam resulted in his displacement in favor of General Burnside, under whom our guest served at Fredericksburg, where he performed major operations on the field. The defeat of General Burnside at Fredericksburg led to the appointment of General Hooker as Commander-in-Chief of the Army of the Potomac, under whom our guest served at Chancellorsville, where General Hooker was ingloriously defeated. Flushed with continuous victories, General Lee invaded Pennsylvania and met overwhelming defeat by General Meade at Gettysburg, where our guest rendered distinguished hospital service near the line of battle. Following this battle, General Grant was placed in command of the Army of the Potomac, and under his banner our guest participated in the battle of Brandy Station. From the time of his entrance into the army on the Peninsula to the battle of Brandy Station, our guest took part in twenty battles and engagements under Generals McClellan, Pope, Burnside, Hooker, Meade and Grant, successively—the great commanding generals of the Army of the Potomac. What a glorious record to have served under every commander of the Army of the Potomac! Part of this time our guest served as First Lieutenant and Assistant Surgeon of the Eighth Regiment, N. J. V., with which he entered the service. From this command he was detailed by General Hooker as Surgeon to the Artillery Brigade, Third Army Corps, in which capacity he served as Acting Brigade Surgeon for eighteen months. Upon accepting this detail he was presented by his regiment with a sword and sash. He also served by special detail on the staffs of General Hooker, French and Sickles. On account of the severe illness of his father, he was obliged to resign from the army in 1864 and return to Camden, the oldest city in the world, because it has always 'Haddon avenue.'

"What an honorable record is here presented by our guest as a surgeon in the Civil War; not greater, however, in the arts of war than in the

peaceful pursuit of his profession. He is the only member of this Society who wears the button of the Loyal Legion and, with the exception of our honored colleague, Dr. Blake, he is the only member of this Society who rendered service on the field as a commissioned officer. Following the Civil War he was commissioned Major and Surgeon of the old Sixth Regiment, National Guard, now the Third Regiment, of which Major Mecray is the Surgeon. What marvelous advances in surgery our honored guest has witnessed since his service in the Army! Then gangrene stalked forth in the Army hospitals in relentless defiance of the surgeons and destroyed thousands of soldiers; now this disease has been banished to oblivion by modern surgery. Penetrating wounds of the abdomen and hip-joint were generally fatal. More soldiers died from disease than from wounds. Now, through antiseptic surgery and modern sanitation, the death rate in war has been reduced many fold, as shown by the Russian-Japanese war. Great, indeed, has been the progress in medicine and surgery since the Civil War, and though this present age has its special problems to solve and evils to combat, yet we may congratulate ourselves that much of the suffering and fatality of war has been mitigated through the astounding advances in science made by the medical profession. The medical corps of the Army to-day is the finest staff corps in the Army, in virtue of the highest recognition of medicine and sanitary science now accorded by the War Department.

"The record of our guest after his return from the Army has been phenomenal. He served as Secretary of the Camden County Medical Society for twenty-five years and, upon the completion of that term, it was the pleasure of the Society to present him with a series of engrossed resolutions expressive of its appreciation of his services.

"In 1866 the Camden City Dispensary was incorporated. Most of you are familiar with the history of this institution. A balance remaining from the fund raised by our citizens for hiring substitutes during the Civil War was used for the founding of the Dispensary. Our distinguished friends, the beloved Marcy and the classic Stevenson, with the accomplished father of our guest, were among the incorporators. In the charter, it was provided that a majority of the trustees should be members of the Camden City Medical Society. This placed the institution, gentlemen, absolutely in the possession of the medical profession of this city. What wise forethought, what keen penetration, guided the action of the incorporators, to whom we should be profoundly grateful. As a result, you are privileged to enjoy the comforts of this building, which has not its equal for society purposes in the State of New Jersey. Our 'guest of honor' has been Secretary of the Board of Trustees of the Dispensary for thirty-three years. Tell me, Mr. President, if, in your knowledge of charitable institutions in this State, you can recall any physician who, for the sake of charity and love of his profession, has rendered longer and more continuous service than our honored guest has rendered as Secretary of this institution?

"In 1868 the Children's Home was founded, with which our guest has been continuously connected since its establishment, and of which he is now Medical Director.

"In 1887, when the Cooper Hospital was opened

for the reception of patients, our guest was made chairman of the attending staff, and is now Medical Director and member of the Board of Trustees.

"In his long continued service in these three institutions, with their frequently changing medical staffs, doctors coming and doctors going, who can say that he had given other than a 'square deal'?

"In 1889 our distinguished guest, following in the footsteps of his father, was elected President of the Medical Society of New Jersey, and, in his address to the Society, advocated the establishment of a State Medical Library, and the publication of the transactions in journal form—both of which suggestions have been recently adopted. At this time Rutgers College conferred on him the degree of Master of Arts.

"Again let me repeat, what an honorable record of service our guest has shown in his association with these organizations and, when taken in connection with his private life in the practice of medicine and his steady adherence to the ethics of the profession, we all can join in saying, in the words of Tennyson,

"And thus he bears without abuse
The grand old name of gentleman."

"The church has been a powerful factor in developing the character of our honored guest. Since early boyhood, he has been a communicant of St. Paul's Protestant Episcopal Church of this city; to-day, he occupies the position of Senior Warden, an honor which indicates the confidence and esteem in which he is held by his brethren in the faith. Young men of this Society, let me exhort you to take this devotion to the church as an example worthy of your imitation. No physician can afford to ignore the Christian Church. The broadening and elevating influences of Christianity are indispensable to the highest development of professional character, and the best results in your profession can only be accomplished by uniting with the teaching of the Great Physician.

"Permit me to say further that our honored guest has always stood and to-day 'stands pat' in favor of higher medical education as demanded by the State of New Jersey through its Board of Medical Examiners. In the action recently taken by our State Society in recommending to the Governor, physicians for appointment on the State Board of Medical Examiners, our guest joins with our State JOURNAL in recognizing, I am sure, the advisability of the State Society recommending only those physicians who hold credentials of an academic education at least substantially equal to those required by the statute, of applicants for the medical license of New Jersey.

"If, in recounting the record of our 'Guest of Honor,' I have failed to do him justice, I feel that your memories will supply the omissions from your personal experience and long association with him.

"In conclusion, Mr. President, members of the Camden County Medical Society and most welcome guests, permit me to commend to your esteem and regard the soldier, the physician and surgeon, the medical director, the churchman and the fellow of the Medical Society of New Jersey—Dr. H. Genet Taylor, whom you have honored to-day."

Do not litigate tumors of the navel without making sure that intestine is not included within the ligature.—*Amer. Jour. of Surgery.*

THE JOURNAL

OF THE

Medical Society of New Jersey.

NOVEMBER, 1906.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any one failing to get the paper promptly will confer a favor upon the Publication Committee by notifying them of the fact.

All communications relating to the JOURNAL should be addressed to the Committee on Publication.

LIFE INSURANCE COMPANIES THAT ARE NOT SEEKING CHEAP MEDICAL EXAMINERS.

We herewith publish a list of the life insurance companies paying a \$5 flat fee, as far as known to us. If our readers know of others they will please inform us:

Ætna Life, Hartford, Conn.
Citizens Life, Louisville, Ky.
Capital Life, Denver, Col.
Fort Worth Life, Fort Worth, Texas.
Manhattan Life, New York City.
Massachusetts Mutual Life, Springfield, Mass.

Mutual Benefit Life, Newark, N. J.
National Life, Montpelier, Vt.
Northwestern Mutual, Milwaukee, Wis.
Pacific Mutual Life, San Francisco, Cal.
Penn Mutual Life, Philadelphia, Pa.
Reliance Life, Pittsburg, Pa.

We believe these companies are thoroughly reliable, that they do not pay their officers excessive salaries, and are not mixed up with trusts or political parties. They should be favored in every way possible by the members of the medical profession.

Apropos—We note at the head of an advertisement in one of the State Medical Journals the following: "No Yellow Dog Funds, No Campaign Expenses nor Contributions, No Officers with \$100,000 per year Salary."

We believe that the discussion in the matter of the insurance companies vs. the medical profession as related to fees should be brought clearly before the public. If not

in the newspapers by carefully prepared tracts as done by the Texas Insurance Committee. We call attention to the article in another column on the subject, entitled "Insurance Tracts" from the editorial columns of the *Texas State Journal of Medicine*.

Attention is also called to the circular, on this subject, issued by the Kentucky State Medical Association's Committee.

NEW JERSEY SANITARY ASSOCIATION.

The announcement of the thirty-second annual meeting of the New Jersey Sanitary Association will be found in another column. An excellent program, embracing many papers, by prominent men, on practical subjects, gives promise of an interesting and profitable meeting—to which members of the medical profession generally are invited. This Association was organized by the members of the committee of our State Medical Society during their persistent effort for a period of more than ten years, to obtain from the Legislature a law creating the State Board of Health, which was finally passed and the Board was organized in 1877. We believe that the Sanitary Association contributed in no small degree to the success of the effort, being composed not only of a large number of members of our State Medical Society, but of a still larger number of able members of other professions—college professors, civil engineers, lawyers and prominent business men.

Our State Society has always been well represented in its counsels, and our members have contributed largely in the presentation of papers and in the general work of the Association. Every one conversant with the work of that organization, we believe, has been impressed with the importance and general excellence of its work and the scientific, practical and valuable character of most of the papers presented at the annual meetings. There is a growing impression, however, that it lacks two very important essentials for the increase of its efficiency and the extension of its influence—

its membership should be largely increased, and the dissemination of the valuable information contained in the papers presented should be much more extensive. We commend this Association as worthy the practical coöperation of our membership, not only because it will greatly extend the influence of the medical profession, but also because we cannot unduly magnify the importance and claims of Preventive Medicine.

Preventive medicine is the crowning glory of the medical profession, for it is the highest type of unselfish devotion to the public good the world has ever witnessed—it virtually means the profession sacrificing largely its pecuniary emoluments for the benefit of humanity. If perfect, absolute success in attaining the aim and end sought were possible, the practitioner of medicine might be obliged to seek other occupation to earn a livelihood, especially if contract practice and cheap insurance fees are tolerated. Here is one of the distinguishing differences between the true physician and the quack or nostrum manufacturer or vender; with the latter it is a pure matter of commercialism—of dollars and cents, with little thought or care of their patrons or the public welfare, and they are making thousands, some millions, in imposing upon the credulity of the ignorant and unreflecting.

The Nestor of American surgery—the late Prof. S. D. Gross, M. D., LL. D.—said a quarter of a century ago: “The great question of the day is not this operation or that, not ovariectomy, or lithotomy, or hip joint amputation, which has reflected so much glory on American medicine, but preventive medicine,” etc.

The popular mind is incapable of properly estimating high professional attainment, or of distinguishing real knowledge from boastful pretension, and finds cause from withholding its confidence, not in any deficiencies it can discover, but in the false allegations and assumptions of those whose interest it is to deceive and mislead it. * * * You cannot make a philosopher of a natural fool. A man of *mere* learning, of *mere* knowledge he may be; but cram his cranium to its utmost capacity with these things, unless you can make him think, he is but an accomplished fool after all. Let medical men frown upon an injurious pub-

lic sentiment which would thrust such material upon a learned profession.—*Dr. S. H. Pennington, President's Address, 1849.*

If a class of men convert an honorable profession into a trade or traffic in life and health—with what feelings should we speak of them; what words would be too harsh to characterize such baseness and deception? There may be some, we hope not many, connected with the regular profession, who are but little or nothing better. They are those who, without liberal or high-minded views of their calling—without a proper appreciation of their heaven-born vocation,—pursue it for the sake of the dollars and cents, and thereby convert it into a trade or traffic. It is to such, we believe, that empiricism, in a great measure, owes its existence. As the whole physical body suffers from a cancer, or malignant fungus of the surface, so does the whole medical body suffer from the contamination of those who use their noble calling for no better purpose. * * * It is by educating the profession, by elevating the standard that this evil is to be eradicated.—*Dr. A. B. Dayton, President's Address, 1855.*

The true physician feels that he has in charge the physical welfare of his species, and nothing that relates to hygienic or preventive science is foreign to his occupation. In fact, as an art, independent of its relations to business, it has no higher triumphs than in seeking out and abating the sources of human misery. * * * Even in an economical point of view, the application of the laws of hygiene is desirable, inasmuch as disease and mortality deduct from the industrial wealth of a nation, but in the higher and more important aspect of blessing to humanity, there is the highest appeal to our professional and personal effort.—*Dr. Ezra M. Hunt, President's Address, 1864.*

At a well attended meeting of the Board of Trustees of the Medical Society of New Jersey, held at Trenton, October 16, the question of submitting to the Governor of the State, for his consideration, names of medical men for appointment on the various State Boards on which medical men are to be appointed, was very fully discussed, when it was resolved, by a unanimous vote, that the matter be referred back to the State Society for further consideration at the next annual meeting.

An editorial on Medical Legislation is deferred till the December issue of THE JOURNAL, awaiting a communication from the Chairman of the Committee on Legislation.

The Medical Library Association of Newark, N. J., is accumulating a good working library, thus supplying the need of an accessible practical library of current medical literature for the practitioners in that busy center. They have a fine list of current medical journals and many of the best reference books, well cared for, in excellent quarters—in the Newark Public Library, centrally located. There the busy man can stop for a short time and look over the current issues, or an investigator can find, if not the books he needs, at least complete indexes of any medical work that has been published and, for the asking, have it procured for his use in a day or two.

At the Atlantic City annual meeting we were pleased to learn that three other County Societies had followed the good example of Essex in starting medical libraries, and we have noticed that in other States this movement is receiving increased attention. It is one of the signs of the decided scientific advance in our profession. We are glad that our physicians are appreciating the advantages of such libraries and are using them.

In reply to several inquiries concerning the time of the appearance in THE JOURNAL of the papers read at the annual meeting of the State Society and those forwarded by the Reporters and Secretaries of County Societies, we would say that the rule of the Publication Committee is that those read at the State Society meeting shall have precedence, and as far as possible in the order on the program. The tardy return of proofs of both papers and discussions has prevented the observance of this rule heretofore, but hereafter they will so appear. Dr. Baer's paper, read before the Camden County Society, is admitted in this issue because it was forwarded nearly a year ago but did not come into the editor's hands until July. We take this occasion to thank the Reporters and Secretaries for some excellent papers received which were read before County Societies during the past month, and we will be pleased to insert them in THE JOURNAL as early as is consistent with our rules. An occasional brief paper may be admitted with the State Society papers.

Secretaries of the County Medical Societies are requested to report promptly to the editor the names of newly elected members. If the dues are sent—\$2—to Dr. Mercer, Treasurer, they will receive THE JOURNAL.

The JOURNALS are now bound and ready for delivery by mail or express Forty cents per volume (the cost of buckram binding) together with eighteen cents to prepay postage, should be forwarded to the Hardham Printing Co., 243 Market street, Newark, so that the volumes may be shipped at once.

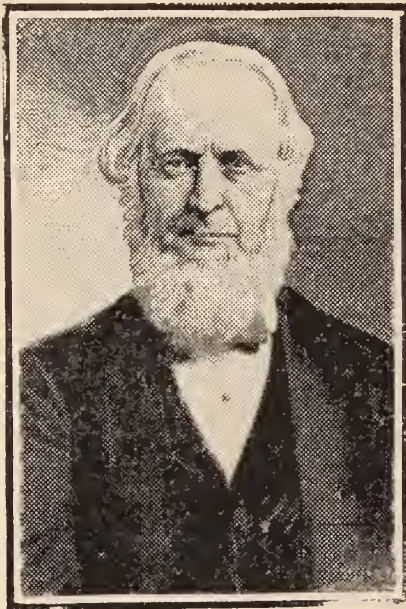
Medical Fees.—The *World's Work*, usually a very conservative magazine, recently had something to say editorially with regard to surgeons' and physicians' fees that seems to us quite wide of the mark. It declared that it had become difficult for the best part of the people of the United States—the well-to-do class who are neither poor nor rich—to receive the best medical and surgical services, for as a rule as soon as a physician or a surgeon became famous he set his fees so high that none but the rich could pay them. It is true, as the writer admits, that the poor can by going to a hospital have the services of the best surgeons free, so that it is possible for the pauper and the millionaire to have the attendance of the most skilful physicians and surgeons "while the self-respecting man of moderate income must take a greater risk at the hands of the less skilful." The writer considers that "this condition violates the spirit of the best medical ethics as it violates the spirit of the best social service."

This is of course an exaggerated statement of the state of affairs and is entirely based on the false supposition that only those who charge very high fees are competent physicians and surgeons. As a matter of fact many of the most competent men in the medical profession charge but moderate fees. The very busy man, who almost finds it necessary to charge high fees in order to keep from being overburdened with work, is sometimes by no means so competent as a modest rival. This is very well known to physicians themselves, who as a rule will not be found crowding to the clinics of the fashionable surgeons, though with them the money question is not an issue. If people would only consult their family physician and let him recommend their consultants or surgeons, there would be little danger of a charge beyond their means on the one hand or of the slightest additional risks on the other. The physician or surgeon oftenest mentioned in the newspaper is far from being the safest or the surest, though his charges may advance with his notoriety.—*Editorial, N. Y. Med. Jour., Sept. 29.* See page 131.

It is surprising how much information can be derived by *abdominal palpation conducted with the patient in a hot bath*, the temperature of the water being gradually raised to 105°F. It usually secures as much relaxation as does the administration of an anesthetic, sometimes even more. In addition to the avoidance of the dangers and the disagreeable features of narcosis, it has the important advantage that the patient is able to call the examiner's attention to sensitive areas.—*Amer. Jour. of Surgery.*

NEW JERSEY'S AGED PHYSICIANS.

**Dr. Isalah W. Condict Dover's Oldest Physician,
Still Practicing at Eighty-nine Years of Age.**



Printed by courtesy of the NEWARK (N. J.) NEWS

ISAAC WINDES CONDUCT, M. D.

Dr. Condict, although he has passed his eighty-ninth birthday anniversary, is still in the enjoyment of good health, and not only retains office practice, but assists his son, Dr. Arthur W. Condict, in operations and consultations. He was born at Succasunna Plains, N. J., October 6, 1817. After securing a good education he taught school for ten years, the last two of which he also studied medicine with Dr. Mahlon D. Canfield; soon after he entered the College of Physicians and Surgeons, New York City, from which he graduated in December, 1847. He served in Bellevue Hospital two years, then went to Blairstown, became, at the solicitation of Hon. John I. Blair, the first principal of Blair Academy, at the same time practicing his profession. In 1851, soon after his marriage, he moved to Succasunna Plains, where he practiced medicine until 1856, when he removed to Dover. He served a short time during the Civil War as a volunteer surgeon. He has refused political office, but was for thirty years an earnest and active member of the Dover Board of Education. He has for many years been an elder in the Presbyterian Church and clerk of its session; when eighty-five years of age he was a delegate to the meeting of the General Assembly of the Presbyterian Church, at Minneapolis; was president of the board of trustees several years, has been active in the Sunday school, teaching now a large class of young women. The doctor is recognized as an able physician and surgeon, who has during his fifty-nine years of practice kept in touch with the progress made in medicine and surgery. He has had ten children, five of whom are living; two of his sons are physicians and two are dentists.

INSURANCE TRACTS.—Our Insurance Committee has prepared and has now in press four Insurance Tracts—short, concise and convincing statements of the protest of the medical profession against the arbitrary enforcement of low insurance fees. There will be 40,000 of them in the form of small folders. They will soon be placed in the hands of every member of the State Association. All physicians who desire to aid in this work will be expected to mail these tracts to the chief medical examiners of the cheap companies they represent. This literature is an expression of professional sentiment, and is not calculated to forfeit one's position as an examiner. They should be handed to every solicitor who enters a doctor's office. Insurance agents are our friends in the fight for just fees. The conspiracy is against them, even more than against ourselves. Ask these solicitors to send them to their companies and general agents, thus demonstrating the local difficulty that has been aroused. These tracts should be given to the newspapers and an explanation of their purpose made to reporters throughout the State. The public are ignorant of this movement on the part of insurance companies; they suppose that doctors receive enormous fees for their services. Publicity will insure an almost unanimous public sentiment in favor of corporations paying professional fees at least equal to those exacted from individuals. The State Insurance Committee will see that all of the officers and general agents, including directors and trustees of all insurance companies operating in Texas receive copies of these tracts. In the meantime let every locality where the physicians are of one mind enter into agreement not to continue making cheap insurance examinations. —*Texas State Journal of Medicine.*

An Incident Which Led to Abandoning Reduced Examiners' Fees.*—"Speaking of cheap insurance examinations reminds me," said an examiner recently. "About ten years ago one of the three large insurance companies announced a reduction of fees for Texas. I was at that time medical director for this company in my territory; they held me responsible for the appointment and character of their medical examiners. The reduction immediately disrupted my machinery; I was constantly revising my list, hunting for cheap examiners, and frequently could obtain none. Letters of disapproval at last became so numerous, and the situation so critical that I took a bunch of letters and started for New York. On calling at the home office, I was invited to dine at The Lawyer's Club with the medical director and several other directors and officials. During the dinner I related the following incident:

"A few years ago I examined Mr. R. for a policy of \$10,000 in a company, call it A, which paid \$5 for the examination. The applicant was a chronic alcoholic, jaundiced, with cirrhosis of the liver. I so stated in my examination and advised unconditional rejection. Twelve days later he was examined by Dr. S. for company B, which paid a reduced fee. The examination was perfect, rated *first-class*, and in the course of events a policy was issued.

*This incident is authentic insurance history. Location, names and dates can be secured on application to the *Texas State Journal of Medicine*, Fort Worth, Texas.

"The applicant was buried a few months later, and shortly thereafter there appeared in my office a representative of company B, who spread copies of the two examinations before me.

"Look at these," said he, "there's something rotten. We have sufficient evidence of fraud to contest the payment."

"They seem all right," I commented, as I ran over the examinations.

"All right, eh!" he exclaimed, "What kind of a fellow is this Dr. S.?"

"Good fellow," I affirmed.

"Good for nothing," retorted he. "It's a damnable fraud or inexcusable blunder; how do you explain it?"

"Easy enough," said I. "He did exactly right. You see, when I made the examination, I started at the head and went down; examined his special senses, chest, heart, lungs, abdomen, clear on down to his toes, and made a careful report. Dr. S. did the same; began at the head, examined his special senses, his chest, his heart, his lungs, and when he got to the diaphragm the money gave out—he couldn't afford to go any further. The trouble, unfortunately, was lower down, and you got your deserts. Better not be sued. It would be better to pay your policy and take your medicine; the facts will beat you. Good day."

"The directors gasped and roared.

"Money gave out! ha, ha, ha!"

"Got to the diaphragm and the money gave out—ha, ha, ha!" echoed around the table.

"As we parted at the elevator, they were still measuring on their vests and saying:

"By George! that's rich, got so far and the money gave out!"

"Gad, the money gave out!"

"At the very next meeting of the directors the former fees were restored and the subject, during the official life of those directors, was never again agitated."—*Texas State Jour. of Medicine.*

Circular Issued by the Committee of the Kentucky State Medical Association.

NO CUT IN INSURANCE FEES.

UNJUST TO THE DOCTOR! DANGEROUS TO THE POLICYHOLDER!

The following Report of the Committee on Life Insurance Examinations was unanimously adopted by the Kentucky State Medical Association on October 11, 1906, at Owensboro, Ky., and the Secretary was instructed to send a copy to every doctor and newspaper in Kentucky:

Your Committee on Insurance has carefully considered the subject of medical examinations and the reduction of fees, proposed by certain of the old line companies, and submits as its report the following preamble and resolutions:

WHEREAS, The recent official investigations of the three great life insurance companies of New York clearly developed that the medical departments were among the few which were not honey-combed with mismanagement or corruption; and,

WHEREAS, The legislation resulting from the investigation intended to cure evils existing elsewhere was at once seized upon as a justification for a long premeditated, concerted and systematic plan for debauching these departments by lowering the standards and compensation for medical examiners, employing and importing into every section recent graduates and men who have failed in practice, as well as representatives from the

lowest grades in the profession, thus destroying what has always been recognized as a fundamental safeguard in sound life insurance; and,

WHEREAS, While nothing could justify such a short-sighted course the official reports of the income and expenses of the insurance business in this state and the country at large, last year, and during all of its history, and the facts in regard to the recent legislation in New York make ridiculous the plea that the action was necessary in the interest of economy or was caused by such legislation. Now, therefore, be it

Resolved, by the Kentucky State Medical Association, in annual convention assembled, That this organized and concerted attempt to lower the standard and compensation of medical examiners all over this country is not only most unjust and degrading to our profession, but is so unsound as a business proposition that it cannot but ultimately prove most expensive and dangerous to all policyholders in these companies, made up of our patrons and ourselves:

Resolved, That a large experience having demonstrated that the thorough and painstaking examination of every applicant for insurance cannot be made for less than five dollars (\$5.00), we recommend that this amount be fixed as the minimum fee, and shall be morally binding on all members in this state on and after January 1, 1907.

Resolved, That in view of the vast interests involved we urge the profession in every county in this state to meet at the earliest practicable day and arrange for organized resistance to this organized and inexcusable oppression. We advise that this be done outside of the Society, and that, so far as possible, it include every reputable physician in the country, whether a member of the Society or not. We advise that the agreement be not made a test of membership, our reliance being upon the justice of our cause, a spirit of mutual helpfulness and coöperation, and our evident duty to protect the best interests of policyholders:

Resolved, That we pledge our cordial support to those companies which have so managed their affairs that they have never been tainted with charges of corruption, and consequently have not found it necessary to degrade their medical subordinates, or otherwise destroy the protection to policyholders, and our Secretary is hereby instructed to publish a list of such companies in each issue of the JOURNAL, upon condition that they are approved by our active and fearless state commissioner of insurance:

Resolved, That we also pledge our support to the International Policyholders Association, which is supporting the United Committees' Ticket, the middle one on the official ballot, in every effort it may make for the protection of the interests of policyholders; that our Secretary is hereby instructed to furnish each County Society in Kentucky with an ample supply of ballots for the tickets supported by this Association for trustees of each of such companies, and that we appeal to the profession in each county and state in the United States to coöperate with us in this movement.

Signed by the Committee.

Read this to every policyholder in the New York Life, Mutual Life and the Equitable. Official ballots will be furnished every policyholder who will write to the Secretary of the Kentucky State Medical Association at Bowling Green, Ky.

MEDICAL EXAMINERS' FEES.

We give the following as specimens of the editorials in the State Society Medical Journals.—*Editor.*

The doctors engaged by such companies as medical examiners are dealing with well-to-do, money making—perhaps wealthy—patrons. * * * It is high time the doctor should be demanding proper compensation for services rendered such patrons. A capable, conscientious medical examiner saves the life insurance company many thousands of dollars. And a minimum fee of five dollars for each insurance examination is, in all conscience small enough. * * * If companies can find doctors who under bid, it will prove at once that they are engaging the recognized low grade and generally incompetent medical examiners. We will not yet believe that reputable Virginia doctors will degrade their professional standing by underbidding a fair and proper charge for the special kind of service required.—*Virginia Med. Semi-Monthly.*

If the doctor is obliged to take the cheap fee "because, having a family to support, he cannot afford to lose the business," is it probable that he is a man who can make an independent, unprejudiced examination? Will he not fear to offend the busy agent who sends the applicant to him by rejecting the physically imperfect, thereby killing the busy agent's commission?

The ignorant physician, the unsuccessful physician, the very young and struggling physician, driven to desperation, or else not knowing any better, will take the cheap insurance fee. Is it likely they can or will make a thorough and unbiased examination? The physician who makes cheap insurance examinations is a traitor to the highest ideals of a grand profession. He is, in effect, a bidder for business in a purely commercial way. If an insurance company employs cheap men and gets incomplete examinations, any idiot can comprehend the fact that there will be an increased death rate among the policy holders in such a company. Who but the policy holders will pay the freight for the carrying on of this foolish, false economy?—*Jour. of the South Carolina Med. Ass'n.*

At the last meeting of the Minneapolis State Medical Association, rather strong resolutions were adopted, and in discussing these and the whole question generally, the *Northwestern Lancet* has some rather pertinent things to say.

"Several of the prominent men throughout the State have written the companies for which they previously made examinations, resigning their office unless the minimum fee was made \$5.00. In the majority of cases the resignations have been promptly accepted and other men appointed to fill the vacancy. A man who has the courage to stand by his principles by supporting a general resolution [of the Association] and resigning his place as examiner is too valuable a man for the company to lose, and the company which accepts such a resignation is not a safe company to insure in. The man who openly accepts an appointment as examiner for such a company after reading the resolution adopted by his State organization is disloyal to himself and his fellow men. He virtually forfeits his membership in every medical society of which he has been a member."

It is, we are sorry to say, quite true that some men will claim to abide by the resolution of their society and yet will continue to do cut-rate work for \$3.00 fees—secretly. Are not these men a menace to the company for which they work?

If they will be dishonest to themselves and their fellows and to their profession, for the small sum of \$2.00, is it not likely that they may be induced to be dishonest in the matter of passing doubtful risks—if the reward is tendered them? Any man who will be dishonest about a little thing of that sort, you may be sure will be dishonest in other and more important things. And yet, doubtless, some of the medical examiners or directors are chuckling to themselves to think how they are fooling the county society and its resolutions, and how some members of the society are doing their work and at their own price. Any ordinary business man may not hesitate to make "presents" in order to get information of benefit in his business; but he does not place much confidence in the honesty of the informer or give him a position of trust.—*California State Jour. of Medicine.*

We have been requested to insert the following in this issue of THE JOURNAL:

Notices have been sent to many physicians throughout the United States and are appearing in the medical and public press regarding an "American International Tuberculosis Congress" to be held in New York City, November 14 to 16 next, and an association known as "The American Anti-Tuberculosis League," which is to meet in Atlantic City next June at the time of the meeting of the American Medical Association.

It should be stated that the gathering in New York next November and the one in Atlantic City next June have no connection whatever with the International Congress on Tuberculosis authorized at the last session in Paris in 1905, which will hold its meeting in Washington in 1908 under the auspices of the National Association for the Study and Prevention of Tuberculosis.

A course of clinical lectures on diseases of the skin will be given by Dr. L. Duncan Bulkley, at the New York Skin and Cancer Hospital, 2d avenue, corner of 19th street, on Wednesday afternoons, commencing November 7, 1906, at 4.15 o'clock. The course will be free to the medical profession.

NEW JERSEY SANITARY ASSOCIATION.

The thirty-second annual meeting will be held at Lakewood, N. J., in "The Laurel-in-the-Pines" Hotel, November 16 and 17, 1906. The first session at 3.30 P. M., on the 16th, committees will report on "The Transmission of Disease by Flies, its Control and Prevention," Dr. G. K. Dickinson; "Organization of Anti-Tuberculosis Societies in New Jersey," Dr. T. W. Harvey; "Education and Training of Health Officers," Dr. J. L. Leal; "Medical Inspection of Schools," Dr. Jos. Tomlinson. Papers will be read on "Smoke, Noise and Stench Nuisances," "How and Why These Things are Bad for the Public," Dr. B. D. Evans; "What has been done in New York City, and how," Dr. Thos. Darlington; "The Method to be Pursued in the Abatement of the Nuisances," S. A. Patterson, Esq.; "Foreign Municipal Ownership of Abattoirs and the Necessity of Proper Meat Inspection," W. M. Gill, V. S.; "The Present Status of Sewage Disposal in the United States and Great Britain," Henry Hewat, "Secret Nostrums and Proprietary Medicines"; "Flood, Control and Conservation of Water, Applied to Passaic River," M. R. Sherrerd, C. E.; "The Progress of Sewage Disposal in New Jersey,"

Boyd McLean, Esq.; "School Architecture from a Sanitary Standpoint," Nathan Myers, B. S. A.; "Suggestions for Obtaining a More Complete Return of Births," David S. South, Esq.

This association is composed of physicians, professors and teachers in our colleges and schools, civil engineers, sanitary engineers, lawyers, clergymen, municipal officers, health officers, architects, plumbers and other citizens of our state, interested in sanitation as related to our homes, our schools and our municipalities. H. M. Herbert, C. E., of Bound Brook, is President; Dr. James A. Exton, of Arlington, secretary.

The High-Frequency Currents in Chronic Rheumatism and Rheumatoid Arthritis.—

Dr. G. E. Pfaler, of Philadelphia, in the presentation of a paper before the Medical Society of the State of Pennsylvania, claimed that the high frequency currents were not injurious to the human organism, that while they were not painful, a sensation of warmth was produced by their action, respiratory combustion was increased, and the quantity of oxygen consumed in a unit of time, as well as that of the carbonic acid eliminated, was heightened. This augmentation of the process of combustion was also indicated by the increase in the amount of urea excreted, while the uric acid was diminished. Since chronic rheumatism and rheumatoid arthritis were probably due to faulty metabolism, high frequency currents were indicated. Mention was made of one case well-advanced rheumatoid arthritis, with a very bad hereditary history, which recovered complete use of all of the joints. Since in chronic rheumatism the pains and the stiffness, which were the chief symptoms of this disease, were relieved by high frequency currents, the treatment was here indicated.

Dr. C. K. Mills, of Philadelphia, in discussing the paper, said that he had seen a striking illustration of the relief of pain, apparently arthroidal, from the use of the X-ray, and in the condition known as "typhoid spine" he had known of marked relief from the use of either the X-ray or of the high frequency currents.

An Analysis of the Kidney Condition of 1,000 Cases of Scarlet Fever Treated by Routine Doses of Chloral Hydrate.—

Dr. B. Franklin Royer, of Philadelphia, presented an analysis of the kidney condition of 300 patients treated by routine doses of chloral hydrate given during the febrile period and continued for several days after all fever subsided, paralleling this analysis with a similar group of 756 patients treated with the usual remedies used in this disease. His study showed an incidence of 5.50 per cent. post febrile nephritis where chloral was used and 7.76 per cent. where chloral was not used, giving an apparent saving of 2.17 per cent. of post febrile nephritis. He presented tables showing detailed analysis of the kidney condition of each group of cases, and concluded that chloral hydrate is of distinct value in the treatment of scarlet fever, and when used in doses of sufficiency to secure light somnolence, does not seem to be a circulatory depressant; that it ameliorates nervous symptoms better than any remedy yet suggested in the treatment of scarlatina; that it allays the itching of the skin; that when given routinely during the febrile period and for some days thereafter post-febrile nephritis appears to be less frequent. This study, in his opinion, seemed to justify the more extended use

of chloral in the treatment of scarlet fever, and a more detailed study of its action on the kidney itself. Dr. Rigg, of Wilkinsburg, said that for a number of years he had been much interested in this subject, and that, although he had not kept detailed records, he could endorse the findings presented. Scarlet fever had been less severe, less fatal, and less liable to complications when chloral hydrate was used than in the employment of any other treatment. Dr. Royer, in closing, stated that in no case did he make his diagnosis of nephritis on the presence of albumin alone, nor did he diagnose nephritis in the earliest stages from one or two purely hyaline casts and albumin.—*Medical Record* report of the Pa. State Med. Soc., Sept., 1906.

Treatment of Acute Hemorrhoidal Inflammation.—*The International Journal of Surgery*, June, 1906, writes editorially regarding the treatment of acute hemorrhoidal inflammation:

"The methods of treatment that have been suggested are numerous and more or less effective. But the following gives pronounced success in practically every case. Twice daily and after every defecation the rectum is washed out with a quart of normal salt solution. Morning and night, after the solution has been expelled and the external parts dried, an anusol suppository is gently inserted. These suppositories, composed of an iodo-resorcin-sulphonate of bismuth, are the most effective means yet evolved for allaying hemorrhoidal pain and distress. The inflammatory process is immediately controlled, the pain of defecation is entirely removed, and the tenesmus and soreness rapidly disappear. If their use is persisted in and careful attention is paid to diet and the avoidance of constipation, a considerable majority of cases will be permanently cured without surgical intervention. The hemorrhoidal tumors grow smaller until they disappear and the tonic effect on the mucosa and vascular structures prevents a recurrence of the varicosities."

DOCTOR'S FEES.

The law of supply and demand regulates medical compensation to a very great extent. It is a natural phenomenon, over which neither the professor nor the laity have much control. Where there are many physicians of equal ability competition grinds down the fees. If the income drops below living expenses the least successful leave the community or take up other means of getting bread and butter. The fittest survive and in every locality the composition of the profession is in a state of constant flux—never the same from year to year and constantly regulating itself to the work to be done. When a man develops exceptional skill his services are demanded more and more—they are bid up by competitors on the other side. He is, indeed, compelled to raise his fees to prevent overwork—strange as that may seem. He would not be doing his duty by his patients if he tried to treat a hundred a day—and that many would crowd his offices if his fees were 25 cents. It is also a fact that a surgeon can do more now than ever before—a few can do wonders as compared with the surgeons of a century ago—and they receive more in proportion by the operation of natural law. How they gained this ability is immaterial to the question—indeed, not all have ability to profit by fortuitous opportunities to learn surgery.—*American Medicine*.

Marriages.

Ellis J. Chapman, M. D., to Miss Ida Mae Hutchinson, both of Bridgeton, N. J., at Shiloh, August 30.

Richard M. A. Davis, M. D., to Miss Ella Ford Hogate Hires, both of Salem, N. J., October 17.

Obituary.

DR. THOMAS ROCKWELL CRITTENDEN.

Dr. Thomas Rockwell Crittenden died at his home in Dover, N. J., September 27, 1906, after an illness of about nine months, though at intervals he was able to be around. For the last five weeks the doctor was confined to his bed and failed very rapidly up to the time of his death. Dr. Crittenden was the son of the late Dr. Ira Crittenden, who was the first physician in Dover and vicinity, and Dr. Thomas R. Crittenden succeeded him in practice. He graduated from the New York City College of Physicians and Surgeons in 1848 and began practising immediately, he being the only physician in Dover for a time. He continued his practice up to the time of his illness.

Dr. Crittenden was born at what was once called Pleasant Valley, in the home which for some years past has been known as the Thomas Oram homestead, located a short distance to the south of the Lackawanna car shops, on August 21, 1822, and has always made Dover his home. He was united in marriage with Miss Louisa M. Hinchman, daughter of the late Guy M. Hinchman, on October 10, 1850, who, with two daughters, Miss Susan H. Crittenden, who resided with her parents, and Mrs. Charles C. Mattes, of Scranton, Pa., survive him.

The doctor became associated with Acacia Lodge, No. 20, F. and A. M., in 1856. For many years he was an active and consistent member of the Memorial Presbyterian Church. He has also served faithfully as Recorder of Dover, was connected with the Board of Health, and up to the time of his death was a member of the Morris County Medical Society. The funeral services were held at his late home Monday afternoon, October 1. Dr. W. W. Halloway officiated.

DR. DANIEL MOORE SKINNER.

Dr. Daniel Moore Skinner, of Belleville, N. J., died of cerebral apoplexy on Wednesday, September 26, 1906, after an illness of seven days. He had been in usual health and on September 19th attended a meeting of the Medical Pension Examiners and responded to sick calls.

He was born on May 1, 1835, at Orange, attended the public schools and went to the University of Michigan, studied medicine at the University of the City of New York, graduating in 1858, and settled in Newark, moving later to Caldwell where he was associated with Dr. Williams. In 1859 he married Miss Mary C. Squier. When the war broke out he enlisted in the Navy and in 1862 was commissioned Assistant Surgeon. He served on the Pensacola, Sabine, and on Admiral Farragut's own flagship. After the war he went to Belleville where he practised up to the time of his death. He was chairman of the Board of Education for several years and Township Physician. He was a member of the Board of Pension Examiners, a member and ex-president of

the Essex District Medical Society, and one of the Council; a member and one of the founders of the Practitioners' Club, and a Trustee of the Society for Relief of Widows and Orphans of Medical Men.

He leaves a widow and two sons, Judge Alfred F. Skinner, and Mr. Frank Skinner.

Personal.

Dr. Alex. McAlister, of Camden, read a paper before The American Medical Association, 1906 on "Whole Milk versus Laboratory Milk" which appeared in the Journal of the Association, Oct. 6. It was discussed by Dr D. E. English, of Millburn, and others. **Dr. H. H. Janeway**, of New Brunswick, in the same issue, describes with illustrations a Bed Lift of his own invention. **Dr. Wm. C. Boone**, of Plainfield, after 25 years service on The Medical board of the Muhlenberg Hospital, resigned, and has been appointed consulting physician of the hospital. **Dr. John E. Blair**, of Burlington, was operated on for appendicitis, Sept. 3, at The German Hospital, Philadelphia. **Dr. Al-bion C. Christian**, of Irvington, has returned from a trip to the Pacific Coast. **Dr. William E. Ramsay**, of Perth Amboy, has been nominated by the Democratic party, and **Dr. Edward E. Haines**, of South Amboy, by the Republican party, for Member of the Assembly from Middlesex County.

Book Review.

NEUROTIC DISORDERS OF CHILDHOOD.

Including a Study of Auto- and Intestinal Intoxications. Chronic Anemia, Fever, Eclampsia, Epilepsy, Migraine, Chorea, Hysteria.

Asthma. Etc.

By B. K. RACHFORD, M. D.

Cloth; 440 pp.; \$2.75.

If one might venture to criticise so concise and readable a book, its most obvious fault is its tone of "cock sureness." Professor Rachford assumes as settled a number of problems in neurology which are still *sub judice*. The practical conclusions that he draws from his assumptions, however, are sound and useful.

His directions in regard to the hygienic, dietetic and medicinal treatment of children will be useful to anyone in general or special practice and are concise and clear. The book will be found especially valuable by young physicians and by older ones who do not care to spend the time to study more elaborate treatises. R. C. N.

New Members of County Societies.—The following have been reported since the official list was reported to the State Society: By Dr. L. L. Hand, Secretary, as having joined the Cumberland County Society: Drs. E. J. Chapman, of Shiloh; Harry E. Love, of Fairton; David R. Streets, of Bridgeton. Dr. A. L. Ellis, Secretary, reports the following from Middlesex County: Drs. John L. McDowall and M. S. Meinzer, both of Perth Amboy, also two others proposed for action at the next meeting. Dr. A. M. Heron reports the name of Dr. Otto C. Thompson, of Cassville, as a new member of Ocean County Medical Society.

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THE NEW METHOD OF MEDICAL SCHOOL INSPECTION.*

By Thomas Darlington, M. D., Commis-
sioner of Health, New York City.

The whole question of the value of the medical inspection and examination of school children admits of no discussion. This paper, therefore, is not a plea for the recognition of its importance, but aims to present the methods used and the results obtained in this work by the Department of Health of the City of New York.

It has long been a recognized fact that the segregation of children in schools afforded most favorable conditions for the transmission of those contagious diseases usually associated with the period of child life. Before any systematic care of these cases was instituted, it is an undoubted fact that large numbers of uncontrolled cases of contagious diseases were to be found in the school rooms, and the contagious element was widely disseminated by the close contact of the children in the class room and play ground, and the commingling of their hats and wraps in the cloak rooms. The master word of modern sanitary science is "prevention" and the health authorities of all communities necessarily bend their efforts toward the elimination of the preventable diseases. The results of these efforts during the past twenty years have been most encouraging, but in no one line has the reward been greater than in the medical inspection of school children.

The movement is one of recent growth.

*Read at the 140th annual meeting of the Medical Society of New Jersey.

In 1842, the authorities of Paris, France, appointed a number of physicians to inspect the schools of that city and incidentally look out for the welfare of the children. In this country the idea was not recognized as of practical importance until it was found that epidemics of the so-called contagious diseases of childhood were flourishing, and their source was, in many instances, directly traceable to the public school. Over fifty years after Paris had suggested the need of this supervision, the system was instituted in a tentative way in the Parochial schools of Philadelphia. It was not a success; opposition was aroused and the work was soon stopped. In 1890, Boston ordered a system of medical inspection of school children. The plan was not enforced until 1894, when it was placed in operation following an epidemic of diphtheria. The following year Chicago followed suit. The other large cities realized the value of the plan and to-day every city and nearly every town in the United States has either a regular system of medical school inspection or has taken some preliminary steps in that direction.

The complete and comprehensive plan in force at present in New York City is the result of evolution. In March, 1897, the Board of Health appointed 150 physicians to regularly inspect the school children of the city. From this date to 1902 it was the policy to exclude from school attendance *every* child affected with any form of infectious or contagious disease. The physicians visited the schools in their charge each morning and examined all children sent to them by the teachers as possible sources of contagion. Thus the primary responsibility of deciding whether or not a

child was ailing devolved upon the teachers. Crude as it was, this system gave excellent results. During the first year, out of 108,628 children examined, it was found necessary to exclude 6,829. Although the teachers proved themselves to be keen observers of the graver forms of disease, many of the minor forms, including eye and skin diseases and pediculosis, escaped their attention. It was therefore determined to widen the scope of the work. As a preliminary step, the Board of Health appointed, in June, 1902, sixteen oculists for the purpose of making a special examination of the eyes of the school children with reference to the existence of trachoma. Over 10% of the children examined were found to be affected; one-third of this number having the disease in so severe a form as to warrant operative interference. The first great advance was made, when, in September, 1902, the duties of the inspectors were widened and each child in the school was personally inspected by them once each week. The second marked change was effected in March, 1905, when it was determined to thoroughly examine each child to determine the existence of non-contagious affections. The schools under the direct supervision of the Department of Health are Public Schools, Parochial Schools, American Female Guardian Society Schools, Children's Aid Society Schools and Kindergartens.

The fundamental principles of the system in force in New York City are:

First.—The repeated and systematic inspection of all school children for the purpose of early recognition of contagious diseases;

Second.—Exclusion from school attendance of all children affected with an acute contagious diseases;

Third.—Subsequent control of the cases, with isolation of the patient and disinfection of the living apartment after termination of the illness;

Fourth.—Control and enforced treatment of minor and sub-acute contagious ailments, with the purpose of diminishing the number of children excluded from school attendance;

Fifth.—Knowledge of unreported cases of contagious disease;

Sixth.—Complete physical examination of each school child, with reference to the existence of any physical or mental abnormality.

The working force consists of:

1. The Assistant Chief Medical Inspector in direct charge of the work. 2. A corps of Medical Inspectors, all of whom are physicians. 3. A Supervising Nurse. 4. A corps of Trained Nurses. Each inspector is assigned a group of schools. These he visits each morning, before ten o'clock, and examines, in a room set apart for this purpose:

First.—All children isolated by the teachers as suspected cases of contagious disease;

Second.—All children who have been absent from school for several days;

Third.—Children returning after previous exclusion;

Fourth.—Children previously ordered under treatment;

Fifth.—All affected children showing no evidence of treatment;

Sixth.—All cases referred to him by the school nurse for diagnosis.

Children showing symptoms of measles, scarlet fever, diphtheria, whooping-cough, chicken pox or small pox are immediately sent home. Cultures are taken in all cases of sore throat to determine the presence of the diphtheria bacillus. In case of small pox, scarlet fever or measles, the Department is notified by telephone so that a diagnostician may at once visit the case, confirm the diagnosis, and order proper isolation. In these cases a postal card is sent from the Division of Contagious Diseases to the Principal of the School informing him, or her, of the presence of contagious disease, with instructions that all children of that family be excluded from school until the termination of the case. Children previously excluded for this class of ailments must bring a certificate of termination of the disease from the Department of Health before they are readmitted. Cases of pediculosis with live pediculi present and all those cases of contagious eye and skin disease who have persistently neglected to undergo regular treatment are excluded. Cases of "nits," acute conjunctivitis and contagious skin disease, have their names recorded and are ordered to go to their own physician, to a dispensary or to the school nurse, for treatment. These children are not excluded, but are re-examined the following day, and as long as they present evidence of treatment are allowed to remain in school. In each case of exclusion, a card on which is noted the name, age and address of the child, the number and location of the school, and the reason for exclusion, is placed in a sealed envelope and given to

the Principal of the school, who, in turn, gives it to the child to take home.

A card index system is kept in each school. This consists of one or more cards for each class room, on which are recorded the name of the child, date of exclusion and readmittance, date upon which it was ordered under treatment, date or dates upon which it was observed to be under treatment, date and manner of termination of the case and a code number indicating the nature of the disease. At the beginning of each term the inspector is required to go through each class room and inspect the eyelids, throat, skin and hair of each pupil. Cases are recorded and dealt with as already mentioned. When a child is ordered to go to the school nurse for treatment, it receives a card on which is written the code number indicating its disease.

In September, 1902, when this work was elaborated, the inspector made a weekly routine inspection of each child in the class rooms. All cases of infectious or contagious disease were excluded. This rigid system resulted in a rather startling condition of affairs. During the first month, 10,567 children were sent home. The school attendance was seriously depleted. All of the graver forms of disease were isolated and cared for by the Division of Contagious Diseases, but the minor forms, including the contagious eye and skin diseases and pediculosis, in many instances received no treatment and were consequently kept

from school for varying periods of time. Truancy was seemingly encouraged. The situation caused much serious consideration, but the remedy for the evil was soon found. On December 1st, 1902, a corps of trained nurses were appointed to co-operate in this work. It was a matter of easy proof that the minor contagious ailments, under appropriate and continued treatment, soon became harmless as regards transmission. The nurses now treat these cases in the school and the affected child is enabled to continue his studies without danger to himself or others. The children sent to the nurse for treatment are only those unable to employ a private physician, or where it is evident that, through ignorance or poverty on the part of the parents, home treatment would be neglected. These children ordered under treatment report to the inspector after a period of forty-eight hours. He then determines if treatment has been instituted, and if so, allows the child to remain in school. Persistent neglect of treatment is considered cause for exclusion.

It may be of interest here to present the table showing the amount of work accomplished by the medical inspectors during the past three years, and also to call attention to the marked diminution in the number of exclusions. From our records it is shown that 98% of the children who would formerly have been excluded, can now continue in attendance at school, with benefit to themselves and no danger to their associates.

TABLE OF WORK PERFORMED BY MEDICAL INSPECTORS OF SCHOOLS IN ALL BOROUGH, CITY OF NEW YORK, 1903, 1904 AND 1905.

	1903	1904	1905
No. of Visits to Schools.....	103,301	101,566	88,964
No. of Children Examined.....	11,301,691	12,236,050	6,285,435
No. of Children Excluded.....	65,294	25,369	18,844
REASONS FOR EXCLUSION.			
Measles	250	1,172	312
Diphtheria	530	155	74
Scarlet Fever.....	66	55	47
Whooping-Cough	364	187	351
Contagious Eye Diseases.....	32,525	10,624	8,833
Pediculosis	21,100	8,717	4,692
Chicken Pox	909	780	937
Contagious Skin Diseases	4,029	2,123	2,018
Miscellaneous.....	5,521	1,556	1,580
Total.....	65,294	25,269	18,844

The nurses are assigned to duty in the more crowded or tenement parts of the city. A special room in each school is set apart for their work. In the morning they receive the children sent to them for treatment by the medical inspector. The diseases treated include pediculosis, ringworm

of the face, head and body, favus, molluscum contagiosum and acute conjunctivitis. The treatment of each of these conditions is established by the authorities of the Department, and the nurse follows a definite line of procedure in each case. The children return to her for further treatment at

regular intervals. After this morning inspection, the nurses make a routine examination of the children in the class rooms. Doubtful cases are referred to the medical inspector for diagnosis. After school hours, the nurses visit, at their homes, all children who have persistently neglected treatment. The parents are advised as to the need of attention. Detailed instructions as to the care of pediculosis are given, and in certain instances the nurse takes the child to the dispensary. It is impossible to overestimate the benefit resulting from the work accomplished by the nurses. During 1905, 67,357 visits were made to schools and tenement houses; 976,092 treatments were given, including 616,384 cases of pediculosis, 268,855 cases of contagious eye disease, and 40,052 cases of contagious skin disease.

For obvious reasons, the nurses are not allowed to treat cases of trachoma, and the large number of such cases ordered under treatment taxed the capacity of the eye hospitals of the city. Accordingly, the Department deemed it necessary to establish two dispensaries and one hospital for the exclusive treatment of this disease. This work is in charge of an ophthalmologist and the medical inspectors assigned to duty have all had special training in this line of work. During 1903, 4,337 operations were performed out of a total of 145,566 treatments given. The improvement of this class of cases may be demonstrated by the fact that during 1905, only 1,460 operations were performed out of 172,327 treatments given. The severe type of this disease is becoming eliminated. The disease itself continues, though of a milder type, on account of our constantly increasing immigrant population.

Another point of interest in this work is that of the visiting at their homes of children who have been absent from school for several days for any unknown reason. During 1904, 861 cases, and in 1905, 623 cases of unreported contagious disease were discovered in this manner. When it is considered that each one of these cases is a source of actual danger to the community, it will be seen that this work is not the least valuable part of the system. Up to the spring of 1905, the whole effort of this system was directed against the infectious and contagious diseases. The system as then used was probably the most comprehensive and highly developed one of its kind in existence. While abating in no degree the constant warfare against contagion, the

work has now been elaborated to include the complete physical examination of each child in the school. This is a subject of far-reaching importance and undoubtedly of the greatest economic value to the community. On March 27th, 1905, the work was so divided that the nurses were assigned to the routine weekly inspection of the children. They follow the same procedure already outlined. All suspected cases of contagious disease are referred to the medical inspector for confirmation of the diagnosis. The doctors thus have time for the more specialized work.

Immediately after the morning inspection has been concluded, the medical inspector receives the children in regular order, and proceeds to examine each one in detail to determine the following points: Condition of nutrition; presence of enlarged cervical glands, anterior or posterior; chorea; cardiac disease; pulmonary disease; skin disease; deformity of spine, chest or extremities; defective vision; defective hearing; obstructed nasal breathing; defective teeth; deformed palate; hypertrophied tonsils; posterior nasal growths; defective mentality, and finally, whether treatment is necessary.

From March 27th, 1905, to March 31st, 1906, the results were as follows:

No. children examined	79,065
No. cases where treatment was necessary	50,913
No. cases of bad nutrition	4,537
No. cases of enlarged anterior cervical glands	22,493
No. cases of enlarged posterior cervical glands	4,989
No. cases of chorea	1,184
No. cases of cardiac disease.....	1,332
No. cases of pulmonary disease....	885
No. cases of skin disease.....	1,574
No. cases of deformity of spine....	674
No. cases of deformity of chest....	500
No. cases of deformity of extremities	663
No. cases of defective vision	24,534
No. cases of defective hearing.....	1,633
No. cases of obstructed nasal breathing	8,974
No. cases of defective teeth	29,386
No. cases of deformed palate	936
No. cases of hypertrophied tonsils..	13,411
No. cases of posterior nasal growths	7,375
No. cases of defective mentality....	1,477

A record is kept, on a special card, of the physical condition of each child. When any abnormal condition is found, a notice is sent to the parents informing them of this fact

and advising that the child be immediately placed under medical care. Later the child is re-examined. If treatment has not been instituted, a nurse visits the family and explains its necessity. Under this system, practically all of the affected children receive appropriate medical attention.

In the matter of correcting defective vision, the results have been most gratifying. Heretofore the remedy for this affection has been that of placing the child on a front seat in the class room. Inability to read the figures on the blackboard or to decipher print has given many children a reputation of stupidity. The teachers have furnished us with numerous specific instances of the supposedly unintelligent and stupid child becoming an apt and bright pupil as soon as proper eye glasses were worn. The results of eye strain are far-reaching, and the relief of that affliction means infinitely more than the ability to see well. The improvement in scholarship of these children has been most encouraging to the school authorities as well as to the Department of Health.

The large number of children with defective teeth gives us a clue to the cause of poor nutrition. Over a year ago, the question of the children going breakfastless to school was brought prominently to public notice. Careful and systematic inquiry was made as to this fact, not only by the Department of Health, but also by the Department of Education. It was found at that time that the proportion of children who actually went to school without any breakfast was almost infinitesimal, and in many of the cases investigated, the reason was, not that there was no breakfast to be had, but that the children, in their hurry to get to school, neglected to eat it. One fact, however, is indisputable,—the children in many instances were underfed. This was due to two reasons: *First*, ignorance and poverty, which mean a badly prepared food supply, lacking nutrition; and *second*, bad teeth, resulting in hastily swallowed, unmasticated food. We are rapidly eliminating part of this evil. It is to be hoped that in time the municipality will supply a nutritious well-prepared noon-day meal for each pupil. At present, however, we are making it possible for the children to properly masticate the food that they can obtain. The question of expense in caring for defective teeth is a vital one. There are few free dental clinics in New York, but a movement is now on foot to establish a number of these dispensaries throughout the city.

Hypertrophied tonsils and adenoid growths have a direct bearing on the susceptibility towards infectious disease, as well as the mentality of the child. Men trained in this line of work have made examinations of the throats and nasal cavities of children deemed backward, and stupid, and consequently isolated in special classes maintained for the mentally defective. The majority of these children were found to have post nasal growths. The removal of these growths has resulted in as great a relative increase in individual intelligence as has been demonstrated in the cases of corrected defective eyesight. The above three classes of cases constitute the majority of the abnormalities found, and it is impossible within the limited scope of this paper to go into detail regarding the others. The importance of the work is unquestioned.

The City of New York has one of the finest systems of public schools in the world. Its cost, immense though it be, is justifiable, but it seems equally just that the municipality should bear its share of the expense in rendering the children capable of assimilating the knowledge so generously supplied them. The work is yet in its infancy. The ideal will be reached when each child can be physically examined twice each year; its physical record following it from class to class in its scholastic promotion and its physical condition as carefully and systematically guarded as is its mental condition. Under this system, the home life of the child is being bettered. Conditions of city life render the housing problem an intricate one, and the constant influx of a more or less ignorant immigrant population, with its lax ideas of cleanliness and personal hygiene, makes the solution more difficult. The nurses visiting the children in their homes come into close personal relationship with the families. Their advice and counsel is welcomed, and improved conditions of hygiene in the homes bears eloquent testimony to the worth of their services.

Our results already have been well worth the money and effort expended. The future holds promise of boundless possibilities. The physical well-being of our future citizens means an uplift in their value to themselves and to the state. Moral and physical degeneracy are closely correlated. In correcting the one, we necessarily tend to eliminate the other, and the ideal in view is that of giving to the City of New York

the highest type of mental, moral and physical citizen.

DISCUSSION.

Dr. Walter B. Johnson of Paterson:—I would like to say a few words in this connection for I have been much interested in this subject for many years. The law which was passed in the State of New Jersey was partially due to my efforts made at one of the meetings of the State Society. It has not been as fully operative as the law in New York State, but it has done some good and we hope it will do more good. But I must call the attention of this Medical Society to these facts. At first the school houses were small and mostly attended by a limited number of pupils; finally the number in attendance increased and it became necessary to erect larger school houses; then they became more crowded and it was necessary to erect still larger school houses, and so step by step the provisions necessary to meet the requirements were met. The hygienic conditions of the school buildings were considered, the medical profession took the initiative and insisted that our school houses must have more ample accommodations, light, air and suitable sanitary appliances, and now we are to consider more accurately and carefully the mental, moral and physical condition of the children, looking to the relief of the resulting bad health, not in consequence of these conditions which have been remedied, but the direct result of overwork caused by the advanced educational standard. Those things are vital, and there is one thing that must be carefully considered—it is time the medical men undertook to further curb the educators. It does not make any difference how hygienic the school houses are, or what the effect of properly constructed school houses may be on the condition of the health of the school children, if the educator is to pile upon the students an excessive amount of work by advancing the standards to a point the average child cannot attain. I say that the school curriculum of the present standard is too much work to place on a growing child. I say this advancement of education beyond the point of tolerance is unwise, more unwise than it was to erect badly constructed school houses. I think the time has come when the medical men should stand up and undertake to further educate the educators; they should not be permitted to increase the work of these children in the public and other schools of this country unless we are to rear neurasthenic generations to follow us. I do not wish to except the colleges. Dr. Nicholas Murray Butler has recently devised a method by which a man could go through college in three instead of four years, working four years into three if his mental capacity was sufficient. If such things are permitted to continue the bright ambitious man will be overworked, and when the time to take up his life's work arrives he must enter the field a physical wreck. I have argued for a careful selection of children, according to their mental grade and condition—that is, the placing of the physically weak in a class by themselves; this is in the right direction. The time has come, I again say, when the medical man shall take a stand and continue the education of the educators in this new direction. The question must be considered from two points of view, not from the educational point

alone, nor from the health point alone. The desire of the educator is the advance of the educational standard. The desire of the medical man is the preservation of the health. Education is an admitted necessity and all are in search of health. Let the educator and the physician join hands and work for one end—the best interests of the rising generation. Let the school curriculum be so arranged that the average individual of average mental capacity may be able with a reasonable effort to meet its requirements. The percentage of the individuals of average mental capacity, as related to all children of school age, is so much greater than the conjoined percentage of the physically weak and the mentally strong that the greatest benefit to the many will surely be accomplished, by the adoption of an educational standard which may be comfortably attained by the student of average intelligence in all grades from the lowest to the highest.

Dr. Edward E. Worl, of Newark.—In Newark we have for examination 44,000 children. It seems to me that where our work often fails, or sometimes fails, is in the earlier detection of contagious diseases. All medical inspectors are strong on pediculosis, a prevalent disease among school children. I believe that Dr. Johnson is right in what he said. Think of our superintendent of schools talking psychology to a freckle-faced boy of fourteen. I think we should return to the old system of three "R's", i. e., Reading, writing, arithmetic—and the children should be trained to be good and healthy American citizens. In our city there are 88,000 citizens foreign born and they are distributed among fifteen nationalities and these are the people who require supervision. There is a large number among them with enlarged glands; these and the many cases of measles are the foundation of tuberculous disease in after life. I do not think we can check the development of measles in the public schools unless we detect these cases earlier. I think this system should be extended, not merely training the mental but the physical condition. We should teach hygiene and physiology more.

Dr. Frank D. Gray, of Jersey City.—It has been a great pleasure to listen to the consideration of this subject and it makes us fairly envious of those living in the metropolis, showing the wonderful work that is being done there. Of course this means that New York City has the where-with-all to do it. It also means that the citizens of New York City are wide awake to the necessity of all this. The fact is significant that the smaller towns are not so wide awake to the necessity of curbing the tendency to overstimulation of the mind as referred to by Dr. Johnson. I wish to call attention to one fact which probably is new to most of us; that there is about to be formed a large committee throughout the country having in charge the education of the public along the lines of public health and sanitation. That was the result of a suggestion emanating from one of the sections at the recent meeting of the American Medical Association, in Boston. I think it was the section on Public Health, and I understand was acted upon favorably by the House of Delegates. Work will be done along this line by a comprehensive committee which will produce a mass of literature on the subject of public health and hygiene to be sent to the public

through various channels. This committee is to consist of members from every state, with a central committee having final judgment upon whatever is to be used. The channels are to be first, professional through medical literature; second, a more popular method of information through the newspapers and various magazines; third, an equally popular form of communication by lectures in public schools, in colleges and public halls, etc. So that I think we have a hopeful outlook, a wide plan, a more efficient plan of reaching the public than any that existed before. We ought to congratulate ourselves upon what the American Medical Association is doing.

Dr. Richard P. Francis, of Montclair.—The usefulness of medical inspection, as Dr. Darlington states, is self-evident. This may be true of New York City and also true in a meeting like this, but it is not true in towns and cities in New Jersey at large. It is only within the past year and a half that the inspection of schools in Montclair has been in vogue and it has been very successful, but we did have a hard time in convincing the town authorities that the medical inspection of schools was useful. It is the duty of all members of this society to endeavor, as much as they can, to influence the Boards of Health and Education to aid in introducing medical inspection of schools in all the public schools of the state. Last year I made some inquiries and found only three or four municipalities where the medical inspection of schools was practiced and that leads me to speak emphatically on this matter. The public of New Jersey is not as a rule educated to appreciate the value of medical school inspection. It should be the aim of this society to educate the public up to this.

Guy Otis Brewster, M. D., of Grantwood, N. J.—I desire to take a few minutes of your time presenting a slightly different point of view than that given by Dr. Darlington. As the doctor has previously stated, there is no room for disputation on a subject the necessity of which is so obvious; one can only elaborate. I believe I have had a doubly practical opportunity of studying the question of medical school inspection. During the years 1900-1901 I held the position of medical school inspector in the city of New York. Since 1901 I have been teaching physical training in the DeWitt Clinton High School of New York. With my first term's work in the High School, I began making complete physical examinations of all the boys in my division of the school and, continuing during the past four years, have now examined over four thousand boys. These examinations were made of the entire body, stripped naked. I have encountered organic disease of the heart, lungs and kidneys. I have diagnosed many cases of diphtheria, scarlet fever, pneumonia, bronchitis, parotitis, and pertussis, and in one week I noted three fatal cases of cerebro-spinal meningitis. In my work in competitive athletics with other High Schools of the city, I have noted boys playing football, baseball and track and field games while suffering from organic heart disease and pneumonia, and have noted fatal results in a number of these cases within a few days. Among the most incorrigible students of the school I have found chorea, exophthalmic goitre and the stigmata of degeneration. Abnormal development from flat foot to curvature of the spine oc-

curred in 40% of the whole number examined. Within the last year I have paid especial attention to the examination of the sexual organs with the result that I have found as high as seven in ten cases examined in one morning, suffering from varicocele. I have noted thirty-five cases of undescended testicle, and a large number of cases of inguinal and umbilical hernia. In the dual relation of teacher and physician I have become confidential adviser to the boys, and in their confessions of self-abuse, sexual excesses, and disease, I have noted a pitiful lack of knowledge of themselves. My plea, therefore, is not alone for medical school inspection, with the detection and isolation of disease, and the correction of abnormal conditions, but for a correlation of medical school inspection with physical education, which should primarily aim to teach the individual sufficient knowledge of himself to assist in his protection at all times of his life.

SOME DIETETIC ERRORS AND THEIR EFFECTS.*

By W. Blair Stewart, M. D., Atlantic City, N. J.

Indiscriminate mixing of foods produces more harm and gastric disturbance than eating the plain food alone. The tendency of our American people is to drift away from a simple to a complex diet; to eat a small quantity of many things at each meal rather than a sufficient quantity of one or two wholesome foods properly prepared and balanced; to devote five or ten minutes to each meal instead of thirty to sixty minutes, all to be in style and to get the habit of the average pushing, nervous, hustling business man of to-day. Dietetic indiscretions produce the major portion of disease (the acute and contagious diseases possibly excepted) hence the necessity for a more scientific study of dietetics and its application in our daily work. A little more sensible advice and not so much medicine. Study a number of good cook books and be in position to advise the proper preparation of food, for when improperly cooked, be it wholesome or otherwise, it will produce digestive disturbances.

Many of our text-books on dietetics advise the use of cereals and fruits at breakfast, with bread and butter and a little meat or eggs. This means to the average reader grape-fruit, tart oranges or strawberries, usually covered with sugar. Next comes the oat, wheat or malted (so called) breakfast foods with sugar and cream; then beef-steak or chops, with hot cakes, muffins, or hot bread and coffee. In one-half to one

*Read at the 140th annual meeting of the Medical Society of New Jersey.

hour there is a fermentive indigestion with all of its train of symptoms, to be repeated day after day. A brief thought on such a combination reveals one of our most common dietetic errors—a strong fruit acid with starch and sugar—an ideal combination for fermentation and one that will impair the strongest digestion in time. All of these foods are wholesome but must be properly used and not abused. It is my custom to forbid the use of strong acid fruit, cereal and sugar at the same meal. Fruit and meat with a small amount of stale bread will be wholesome in most cases. The mildly acid and sweet fruits like prunes, bananas, sweet apples and figs may be taken with cereals in selected cases. If a cereal is taken forbid the acid fruits and omit the use of much sugar. Sixteen years of practical observation teach me that wheat cereals are more easily digested than oat. In fermentive troubles the oat cereals are always forbidden and in many cases all cereals. The critical mind will question the fine points of difference between the different cereals and wonder why use the wheat, rice or corn instead of the oat as starch is in one as well as the others. Chemically and theoretically the starch may be the same, but practically and in the vital process of digestion we are led to the conclusion that starch is present in different combinations and is differently digested and assimilated. To be wholesome a cereal should be cooked for a number of hours so that the starch grain is properly broken and more easily digested. Many people can eat a small quantity of cereal with perfect impunity, while larger portions will cause fermentation. In these cases it is our duty to be very explicit on this point and watch carefully for results.

This leads to a consideration of the widely advertised and over estimated forms of patented, "ready-cooked", "pre-digested," "malting" and dried forms of cereal foods on the market. Many of them have little or no food value and are worthless. Others are fairly good if properly eaten, but who takes time to properly masticate every bite? In many instances they actually irritate the stomach and intestines. There are several very valuable preparations among them, but it is not within the province of this paper to lend advertising patronage. We frequently over estimate the true food value of cereals to the detriment of our patients and the exclusion of other foods. The more refined and bolted forms of wheat do not possess the nutritive value of the rougher forms.

The whiter the bread and the finer the flour the less true food value it contains. The corn cereals are easily digested if properly cooked and are often better assimilated than others. The old-fashioned dish of well-cooked mush with milk, without sugar, is too often neglected. Hot bread and hot rolls, unless well baked, contain living yeast organisms or an excess of soda and, when the latter is used, are hard to digest and are a cause of many dietetic disorders. Subjects of indigestion should never use them, while others should be very sparing in their use. Next in the list to starches comes sugar. It is improperly used by the well and sick and is probably more abused than any one food. Sugar in cereals, coffee, tea, fruits, breads, jellies, ice creams, ices, candies and drinks of all kinds. Children love it and adults seem to think they can not live without it. It is a valuable food but must be used with prudence. In fermentive cases it must be forbidden in any form for a limited time and sometimes permanently. Each case must be a law unto itself and a close study of it must indicate your rules.

Strong coffee and tea two or three times daily, with or without sugar, are absolutely without nutritive value and are taken on account of habit, their stimulant effects, or the want of a hot drink at meals. We know the consequences. A cup of weak tea or coffee in the morning, without sugar, with or without cream, will do no harm in most cases, but in others it must be omitted absolutely. Here, again, no fixed rule can be made, but the subject must receive your closest attention and study. Condiments should always be used very sparingly as they give rise to great digestive disturbances. Wines and liquors can only be mentioned to be condemned as they will always impair digestion if used regularly or imprudently. We must view this subject from a very broad standpoint as no two others will agree upon its food value and digestive actions. My experience in treating users of alcoholic liquors decidedly contraindicates their use as a food product and classes them among the greatest impairers of digestion. Many people can eat corned beef and cabbage with comfort, but if a dessert, pastry, or rich salad is taken at the same meal they will have serious indigestion. A combination of raw clams or deviled crabs, with sliced tomato, meat, vegetables and ice cream, is a common hotel dinner and an ideal mixture to cause cramps or indigestion. At an average course or hotel dinner one will take from eight to fifteen different articles of food and

one to four separate kinds of drinks. This is done daily in our hotels and boarding houses. Is it any wonder that digestive disturbances result and the cause never appears to patient or physician. The information has to be literally pumped out of the patient before he will tell you his intemperance in eating. Any one of these foods will be easily digested if eaten alone, but such combinations, with their great inequalities of digestive requirements, will be sufficient to cause trouble. The beautiful results of a digestive ferment in a conglomerate mixture of foods in a test tube may appeal to the theorist as an argument in favor of such excesses, but such changes will not take place in the stomach, or if they do partially will not prepare the foods for proper assimilation. Our hardiest and healthiest people are those who accustom themselves from childhood to eat any wholesome article of food placed before them. A too limited diet always leads to constipation, headache, bilious attacks, loss of strength and poor health.

Overeating is another error in the diet of children and adults. It is unwise to recommend eating heartily because one is always hungry. Constant hunger is an indication of disease and needs investigation and treatment. Gastric catarrh, intestinal parasites and other conditions cause an inordinate appetite. A small properly selected, well balanced and carefully taken diet will be better assimilated and produce more nutritive effects than the meal of a glutton. Too much food renders one sluggish, heavy, inactive, drowsy and unfitted for brain or physical work. The manual laborer or mental worker will do his best work on a light meal. The full diet of the laborer cannot be properly digested and assimilated by the brain worker. Too much red meat is injurious and tends to high blood pressure, rheumatic and gouty tendencies. Children should never be allowed to overload their stomachs or mix foods as their digestive powers are too easily taxed and rendered almost useless. People past 45 to 50 years should also be very conservative in their diet. They do not need much red meat and stimulant diet as their arterial system needs protection and every precaution to avoid that disease of advancing years, arteriosclerosis. Do not be a man of 70 when you reach 50. Consider well the age, occupation, physical condition, idiosyncrasies, climatic influences and family tendencies of your patient and give dietetic instruction accordingly. The person "whose stomach

is his God" and who believes in eating everything that tickles his palate because he thinks life is short and we live only once, is dangerous to himself, a dietetic nihilist, and must be cautioned in no uncertain terms. The habit of closing every full dinner with desserts is very detrimental and usually causes discomfort to the eater. Dessert after a satisfying meal is that much too much and should be avoided. Children frequently pick at the substantial foods, knowing that the desserts and sweets come last and make these their meal. A word to the thoughtful wise man should be sufficient.

The laity and many physicians fully believe in the old fallacy "Eat plenty of fish because it is rich in phosphorus and is our best brain and nerve food." This is wholly erroneous. The fish eating nations and large fish consumers do not substantiate such nonsense. It can not be shown that a fish diet supplies more or as much phosphorus as some other foods, and it is not entirely certain that a phosphorus diet will improve mental capacity and act as a brain food. Another fallacy is the much vaunted and advertised theory that the character of diet of a pregnant woman will influence the sex of her offspring. Many cases are cited in its favor but is it not entirely probable that in a few thousand experiments by various people, guessing at the prospective sex, a large number will happen to guess right? There is no more rational reason for this than there is for the phase of the moon at the time of conception influencing the sex of the baby, and there are many superstitious people who believe in these signs. Dietetic errors and fallacies could be multiplied almost indefinitely, but those mentioned will serve to call attention to the crying need of our professional study and advice along other lines than drugs. It is wrong for us to rush to see our patients or to see them in the office, write them their prescriptions or give them some medicine and hurry them through for the next one, because we have no time to give them proper dietetic and hygienic instructions. We should be specific in directions on these subjects in every case and see to it that the advice is thoroughly understood and, better still, put it in writing for them.

DISCUSSION.

Dr. Philip Marvel, of Atlantic City—This is the first time I was aware that I was to discuss the paper and, therefore, I have not given it the consideration it deserved. I certainly heartily endorse the paper just read. Perhaps we,

more than other physicians, are brought face to face with the acute disturbances arising from the conglomerate mixtures of diet. Dr. Stewart did not paint the picture too strongly, or color it too deeply, when he referred to the fact that it was not an uncommon thing to find people sitting down at the table and eating from fifteen to eighteen different forms of food. Sometimes in examining the vomitus of patients, I have been compelled to think of the garbage pail; the mixture is little less in the one than in the stomach of the other. I also wish to heartily endorse what has been said regarding desserts. There is little or no question but that the majority of the people would be decidedly better, if they desisted entirely from taking them. When people are past the age of 60 or 70 and have largely given up the activities of life, I question whether it would not be better for all to modify the number of times they eat as well as the amount they eat. I have been working somewhat along these lines, not only with patients but occasionally with myself, not because I am past the age of 60, but I felt that a personal experience would be better than an inferential one. I have taken but two meals a day and endeavored not to make them larger than if I was taking three, and my comfort has been noticeably greater. I am satisfied that the majority of us who are busily engaged, largely with brain work, would do better and live longer if we ate but two meals a day. None of us should ever eat three heavy meals the same day, and especially when unusually engaged or overworked. There is not one of us, if we are careful in studying the cases before us, but will find that they are, to a greater or less extent, less able to perform work with an overcrowded digestion. Those of us who work many hours have found that the liquid diet enables us to perform an amount of work which otherwise would be impossible.

Dr. Stewart's paper cannot be too much emphasized; what he has stated refers not alone to the patients, but I take it, the dictum should be accepted by us all as well as by our patients.

Dr. W. E. Darnall, of Atlantic City.—I do not think there is anything left to say, but what has been said I wish to heartily endorse. I believe that over-eating is as bad as over-drinking, and it is just as intemperate at the table at meals to over-eat as it is to go out on a spree. I think the point already made is a good one regarding crowding the stomach with so many things. If one should learn to eat in a simple way and partake of a simple menu, there would not be so much gastric irritation. A point of importance to my mind is not so much the number of things eaten as that the proximate principles should be in a certain equilibrium, the same for the child as for the adult. One cannot make a meal on meat alone and then expect to have a perfect digestion. It is therefore very important that there should be a proper balance in the dietary. Again cooking is very important; if the food is not properly cooked we cannot expect to flourish on it. Again if the stomach is crowded full with dessert oftentimes we cannot expect to rise from the table in a comfortable condition. This certainly cannot be good for the stomach. When the gastric musculature is overstretched, digestion cannot go on properly. Unless people are in a very active physical condition they cannot con-

sume such fuel as furnished. Those who partake of pork-chops should go out and haul rails each day. If they partake of such a diet they should get up and do some hard laborious work, as on the street or as a carpenter. If they do not do this we all know the seriousness which follows, the danger from arteriosclerosis, Bright's disease, disease of the nervous system and all of the vital organs. By so doing the man is past the hope of ever keeping those organs in good condition. I think that possibly what is now on foot in regard to the adulteration of foods will help us. I think that gastric and other troubles are often due to preserved meats and foods of all sorts. Take salicylic acid in the stomach and it will upset that organ as well as other organs. Dr. Stewart mentioned bread; I was raised below the Mason-Dixon line and I contend that the bread there, the fresh bread, is as healthy as other forms of bread. Go below that line and you will not find cases of chronic gastritis or acute indigestion as you find them up here.

Dr. Henry L. Coit, of Newark.—Apropos of the paper I should like to add one word of endorsement and also to state that I believe a man would generally be better off, especially physicians, with only two full meals a day. While discussing diet I think a word is in order regarding the American breakfast. The English make sport of the Americans on account of the oatmeal pyrosis. There are some things that should be remembered in eating and one is that milk and fruits should not be used at the same meal; milk and meat should not be used at the same meal. When speaking with a Jewish woman once I said that she should never take milk with her dinner when meat was included and she answered that that was not necessary to tell her because it was against her religion. Milk and meat were not to be taken together according to the Jewish code. Milk and fruit are not compatible because of the acid in the fruit which precipitates the casein into hard curds. Fruit may precede a meat breakfast, and milk may be used with a farinaceous breakfast.

Dr. Alexander Marcy, Jr., of Riverton.—I think we all agree with Dr. Stewart that the average individual eats too much, and this is particularly true of medical men. I think you will notice at banquets that there is no set of men that eat more or are in a greater hurry than the medical men, and I have been in several scraps myself. As long as the American plan of hotel living is continued, where they charge five, six, eight and ten dollars a day, furnishing everything that is possible to be had, just so long will the average person try to get his money's worth. It seems to me first of all that the medical profession want to regulate themselves, then the hotel proprietors and then the patients. The continental breakfast is better than ours, and their system of serving meals, as well as the character of the food served, is better for us. It tends to prevent overindulgence. Gentlemen, I repeat, you must first regulate the physicians, then the hotel proprietors, and then the patients.

Dr. Richard Cole Newton, of Montclair.—There can be no complete discussion on diet without quoting from the works of Fletcher. Take his simple rules of eating. It makes no

difference what you eat if you eat properly. Chew the food until it swallows itself and until all the taste has been extracted from it. If you eat that way indigestion, Bright's disease, headaches, etc., will flee away and never return to any of you who "Fletcherize" properly. For twenty long years I was compelled to take a cathartic every night. During the past three months I have needed none. Practically every man eats four or five times as much as he ought to eat, and every woman five or six times. There was a man in Washington doing hard literary work who lived on four corn gems and one glass of milk a day and sometimes on a hot day one glass of lemonade at night. See what Mr. Fletcher did at Yale University—he took the same exercise as the university boat crew that was training for the races. After their exercises all were examined by an expert, Dr. Anderson, who testified that Mr. Fletcher was not so tired from the exertion as were the candidates for the university crew. He was 55 years old and his meals cost him 77 cents during seven days. Eleven cents a day for food was all that he required. The day he was 50 years old he rode 190 miles on a bicycle; then to limber up he rode 50 miles more on the day following. All this was done after he had "Fletcherized" for five years.

**A BRIEF STUDY OF THE CLINICAL
EVIDENCE OF SOME DISEASES
WHICH APPARENTLY EN-
TER THE SYSTEM
THROUGH THE FAU-
CIAL TONSILS.***

By Philip Marvel, M. D., Atlantic City,
N. J.

To state that more than ordinary attention is being paid at the present time to the subject of systemic infections, is a declaration that but modestly expresses the facts. It must be noticeable to the majority who carefully review the weekly and monthly journal contributions, that the medical thought of to-day is more closely following the evidence and manifestation of the onset, whether rapid or insidious, and the remote sequence of disease, than perhaps ever before within our memory. Old and new theories, which have hitherto been reasonably satisfactory to at least a portion of the profession, are no longer regarded as "preserves," exempt the searchlight of advancing science, or forbidden as a trespass to the progressive student, seeking the truth. The observations of the past were full of hopes, which have been partially realized.

From the beginning of the early studies in morbid phenomena and macroscopical

observations of pathogenic change, time aided by scientific and mechanical assistance, has brought us to realize that a knowledge of pathology, microscopy and bacteriology are, and must ever remain, the clinician's richest inheritance aids. But we are to be cautioned against being led too easily by the hope, and the glamour of the discovery of some new bacillus, or possibly the recognition of a hitherto unobserved instance of disturbed function, the result of a toxemia, lest we lose sight of the real object of the practice of medicine—namely, the immediate and permanent relief of the patient; or of being too much impressed by the strictly scientific side of our profession, to regard the morbid phenomena with that interest which properly belongs to disease, thus overlooking the symptomatic evidences which directly point to its etiology.

From the foregoing, it must not be inferred that I do not recognize the great assistance which contributory science has rendered in the establishment of the art and practice of medicine, upon its present advanced scientific basis. Considering more particularly that portion of the subject under discussion—namely, the tonsil and its relative influence in systemic disease—reference to the peculiar position which the tonsils occupy seems permissible at this time.

If volumes were written speculative of the probable function and possible advantage of the tonsils and their relation to our future health, observing them first as sentinels guarding the most threatened and dangerous port of entry to the body, viewed from the standpoint of disease, and secondly after having undergone pathogenic change, becoming one of the greatest menaces to the individual's health, our absolute knowledge of the dual role played by them in health and in disease would be as astounding as it is incomplete. When studied from their relational occurrence with the number of diseases with which we find them, we are led to believe that they have become the avenues for more serious and farther-reaching disturbances, than even the appendix. I am aware that my position is as yet without verification by statistical data, but the number of serious and fatally terminating diseases, which follow tonsillar invasions, warrants both the comparison and the assertion. Doubtless, the fatalities, direct and indirect, of the former alone, owing to the very much greater number attacked, are many times more than in the latter, to say nothing of the thousands who are

*Read at the 140th annual meeting of the Medical Society of New Jersey.

left partially, and even totally incapacitated.

The tonsils, situated as they are between the faucial pillars and on either side of the pharynx, are analogous to and differ but little, if at all, so far as known, from other lymphatic glands, excepting in the fact that the former located, as they are, contain furrows and crypts, readily communicating directly with the buccal cavity. They are in size somewhat uniform when healthy and vary from 12 to 20 mm. in longitudinal and vertical diameters. However, owing to inflammatory changes, to which they are frequently subjected, the size and regularity of the surfaces may be greatly changed. They are fairly well developed by the end of the first, though not completely so, until the latter part of the fifth year; are encapsuled in mucous membrane, sparsely supplied with connective tissue during childhood and early life, and when hypertrophied or otherwise changed by disease, the resistance to bacteria during this period is so light that the contrast, with the growing immunity against infections in advancing age, when the capsule becomes thickened and protective, is marked and noticeable. The epithelium covering the surface of the hypertrophied faucial tonsils is considerably thickened, and at the external openings of the crypts, the same condition is found. In the deeper parts of these crypts, however, this excess of epithelium is not found, so that no obstacle is offered to the entrance through them of organisms from without. Immediately below the semilunar vault of mucous membrane which covers the particular part of the tonsil in front is a depression or chink. This depression is the opening into a relatively large cavity lying in that area of the tonsil which is concealed by the soft palate. In 82 out of 100 individuals examined by Killian, it was found that a probe entered from this point to a mean depth of 1 cm. entered the soft palate, either forward, upward and outward, or backward, upward and outward. This is a distinct anatomic entity, undoubtedly possesses clinical interest and was called by His the supertonsillar fossa. It may become the seat of suppuration, which may be drained in a very imperfect manner and hence give rise to a continuous throat irritation. It may be the seat of calculus formation, or masses of lepto-thrix may grow in it and lead to attacks of pharyngomycosis.

Physiologically studied, the tonsils may be considered definite organs, actively engaged in the production of lymphocytes. This function, possessed as early as the lat-

ter part of foetal life, demonstrated by Stohr (*Iur physiologie der Tonsillen*, biol. cuitib, 1882, Vol. 2, No. 12), continues until destroyed by disease or accident. "The follicles contain germ centers, in which lymph cells may undergo mycotic change and also afford a free passing of lymphocytes directly into the lymphatic circulation and through the mucous membrane into the mouth. These organs contain both afferent and efferent lymph vessels and are responsible for a large outflow of lymph. A large number of the cells which normally pass out are lymphocytes, which, together with varying numbers of leucocytes, form the salivary corpuscles. In examining secretions collected from the non-inflammatory mucous membrane of the tonsils, in addition to epithelium and micro-organisms, may be found leucocytes and lymphocytes, and not infrequently many bacteria in the former. Whether these secretions should be regarded as physiologic or pathologic is yet undecided, but from the foregoing it is obvious that the situation of the tonsils, their anatomic construction and physiologic function predispose them to early primary disease, and very possibly to secondary transference of bacteria and their toxins through the lymphatic and circulatory streams to other structures." (Some Clinical Observations in a Case of Acute Lymphatic Leukemia, Suggesting Infection as an Etiologic Factor in the Disease, published by me in J. A. M., 1906).

Were it necessary to prove Koch's law in every case of suspected systemic infection, namely, "the finding of the same micro-organism in all cases of the respective disease; the limitation of its occurrence to the latter; the possibility of explaining the symptom-complex from the mode of distribution and the method of action, of the sepsis of bacteria, which is supposed to be specifically pathologic, and finally, every inoculation of the pure cultures of the bacterium into other organisms to produce in the latter an affection similar to the original disease," mine would, indeed, be a difficult position to support. But, fortunately, there remains but little doubt that, even without the proof of isolated specific bacteria, an infection may be determined with great certainty when studied from its usual typical morbid phenomena. It is a fact at this time that but few of the infectious diseases can be recognized by their specific bacteria. Hence, how necessary, for the present at least, that we hold on to the clinical phenomena of these

diseases as our most positive means of differentiation and recognition. Thus far there have been but comparatively few instances in which the pure cultures of disease-bearing bacteria have been taken from the blood or lymph streams. We are, therefore, compelled to accept a reasonably large number of diseases as recognizable only by their symptomatologic and morbid phenomena and must so continue to differentiate them until bacteriologists are able to bridge the chasm which in disease continues to separate the known from the unknown.

Among the bacteria which grow and propagate within the organism, which I believe to be the immediate source of many systemic disturbances with which the practitioner must deal, and which for our present purpose may be referred to under two classes or heads, differentiated according to the manner of their growth and of their deleterious action upon the structural tissues of the body; viz., first, those that seemingly multiply only at the point at which they find entrance into the organism, and the immediately surrounding areas, types of which are diphtheria, erysipelas and tetanus; and second, those that are widely distributed throughout the economy during the progress and development of the disease, either by metastasis or through the blood and lymph channels, thus transferring the bacteria and their toxic products readily from one point to another, as is evidenced in pyæmia, tuberculosis and enteric fever; or by uniform distribution of the bacteria through the circulation and the lymph channels, types of which are the septicæmia, referred to in a general way, and in which group may be found the different cocci. The first division, or that form of bacteria which apparently centralize their forces upon local foci or separate portions of the body, are also capable of, and do in many instances, impress the whole system, and whilst their special bacilli have not been found traversing the blood and lymph streams, the toxins which arise therefrom either locally or systemically impress the body so as to impair and eventually destroy the functional forces within the individual organ or organs, thereby occasioning disturbances which lead to destruction of the tissue and death. It may seem a little strange, when viewed from our advancing knowledge of most subjects in medicine, that more careful observations have not been hitherto made and greater importance attached to the frequency with which the tonsils have been the seat of inflammations that subsequent systemic disease. If the tonsillar

have often become the primary source of an invasion be carefully observed, many severe and otherwise unexplainable diseases will be directly traceable to a tonsillitis, tonsillar hypertrophy or tonsillar abscess; and it is not without interest to note that the greater number of the acute contagious fevers exhibit their earlier manifestations in a tonsillar and pharyngeal inflammation. In too many instances to be overlooked, the first and only evidence for a period of several days of the systemic disease which follows, is that of a simple or aggravated tonsillitis, and in these cases, as in other forms of tonsillar involvement, there may be manifest only a number of patches of bacterial accumulations in the crypts or furrows, with or without an invasion of the follicles, which is in no wise characteristic of any particular form of a disease. Doubtless all of us have watched with much concern and anxiety an indifferent tonsillitis or pharyngitis, that was influenced but little, if at all, by treatment, after a few days suddenly burst forth into a fully developed acute contagious eruptive fever, as scarlatina, morbilli, varicella, and even variola, without having previously exhibited any positive symptomatologic evidence of either. The few cases in which I have been permitted to observe the earliest manifestations of the acute contagious fevers in the past two years, have all presented a tonsillar inflammation varying in severity from a marked hyperæmia with some inflammatory change, to a severe angina with evidence of structural involvement. From the foregoing, it is obvious that a study of these acute contagious fevers from the point of early invasion will be of increased interest to the medical internist.

The particular or special role played by the tonsil through the lymphatic system in any of these diseases and particularly in the exanthemata, remains a question yet to be worked out, and is outside of the limitations of this paper to discuss. Therefore, reference to the same is made merely to call attention to the fact that in many instances, if not in all, the lymph and blood channels are known to be in some way active in the transference of the special bacillus or its toxins to the tonsils from some remote and yet unknown source within the body, or more probably, from the locally attacked tonsil to a special organ or organs, or to any and all tissues of the general economy. The latter seems not only the more likely, but in fact, has in its support the preponderance of evidence from observation and clinical phenomena in proof of the same.

Thus, in a brief and fragmentary way, I have referred to some of the possibilities arising from the subject of infection in the broad scope of the subject and shall from now on confine the discussion to the report of cases that have come under my observation and in which the primary evidence of the attack has been observed first in the tonsils. In passing from this to the study of the special reports in question, it is interesting to note that the proximity to, and the large distribution of the lymphatics to the heart, lungs, kidneys, and to the pleura and other serous membranes, make these organs and specialized tissues, particularly accessible by the lymph streams and very vulnerable to infections entering the body by way of the tonsils, and evidence is not lacking to show that these are the organs most frequently involved. The medical literature of to-day is rich with reports of many diseases in which the earliest evidence of the primary involvement was an acute tonsillitis. A hasty review of the same has enabled me to enumerate its occurrence in at least twenty-six distinct diseases, namely: Tuberculosis, influenza, acute rheumatic fever, chorea, diphtheria, scarlet fever, measles, erysipelas, typhoid fever (those rare cases in which intestinal lesions cannot be demonstrated), pneumonia, pleurisy, endocarditis, pericarditis, cervical adenitis (tuberculous), appendicitis, cerebro-spinal meningitis, leukemia, nephritis, Hodgkin's disease—pseudo-leukemia, pyemia, septicaemia, septico-pyemia, actinomycosis, erythema nodosum, cryptogenic jaundice and Vincent's angina. It would be tiresome and unnecessary to attempt a detail of all these cases; hence, I shall refer to only a few of those most likely to be met by the general practitioner; as diphtheria, nephritis, rheumatism, endo-, myo- and pericarditis, pleurisy, pneumonia, otitis media, mastoiditis, erysipelas and rheumatism septicaemia.

ABSTRACT OF CASES.

Case I. Tonsillitis of four days' duration, followed by pain in right side; intercostal region, slight febrile temperature, cough and subsequent loss of flesh, with dyspnoea on exertion. Two weeks thereafter the patient came to the shore, when a pleurisy with effusion was diagnosed and two and a half quarts of fluid removed.

Case II. Follicular tonsillitis, followed by erysipelas. A married lady about 32 years of age, mother of three children, in good health, visited the theater and was conscious of sore throat first while there. endocardial changes were exceedingly mark-

The following morning there was a marked follicular tonsillitis. On the evening of the same day erysipelatous inflammation began over the nose, which rapidly spread so as to involve the whole face and scalp; hyperpyrexia reaching 106 degrees; febrile albuminuria, no casts, nor nephritic debris. After two weeks normally convalesced.

Case III. Tonsillitis complicated by influenza and malaria, followed by nephritis. A boy 13 years old previously healthy, had had typhoid fever six months before. Careful examinations had been made of the urine, which were always negative. Hyperpyrexia accompanying the tonsillitis, suspicion was aroused, and careful examination was made of the secretions in the throat, in which the Pfifer bacilli were found, and the case progressing unsatisfactorily, blood examinations were made and malaria plasmodia were found. Anti-malarial treatment was instituted and the fever subsided. Examination of the urine in the first place showed negative evidence. A second examination a few days afterwards showed some albumin, which was subsequently followed by evidences of acute nephritis. The individual has to-day a marked albuminuria, with occasional granular casts.

Case IV. Streptococcic tonsillitis followed by articular rheumatism, endo- and myo-carditis and nephritis. Miss M., age about 30, perfect specimen of womanly physique and perfect health, was seized with tonsillitis, which gave rise to suspicion of diphtheria. Laboratory examination was made of the secretions taken from the tonsils, and declared to be streptococcic. As the tonsillitis subsided, there immediately followed articular pains, which became more and more aggravated and complicating, while endo- and myo-carditis, of a most severe type, followed. The urine examination showed in the beginning slight albuminuria, but otherwise negative. The albuminuria became increased during the endo- and myo-carditis and subsequently showed evidence of an aggravated acute nephritis. This patient recovered.

Case V. Streptococcic tonsillitis. A gentleman of about 28, married, civil engineer by profession, history of perfect health, was seized with tonsillitis, giving suspicious evidence of diphtheria. Laboratory examination was made of the secretions from the tonsils and the case declared to be a streptococcic infection. No Klebs-Loeffler bacilli were found. The tonsillitis progressed slowly, with declining temperature, endocarditis and myocarditis followed. The

ed and left very loud blowing murmurs with both systolic and diastolic action of the heart. Pericarditis was not observed at the time, but subsequently when the patient was convalescing there was evidence of pericardial effusion. After a long convalescence, the patient recovered.

Case VI. Acute Lymphatic Leukemia. A young girl 13 years old, history of good health with the exception of pneumonia four years previously, had a severe acute attack of tonsillitis, with general glandular involvement, beginning primarily after the tonsillitis in the cervical, submaxillary and axillary glands; subsequent enlargement of the liver, spleen and thyroid gland; marked anaemia, acute nephritis, hemorrhagic di-crasia, pulmonary oedema, asthenia and death.

Case VII. Follicular tonsillitis, with influenza, followed by otitis media, secondary mastoiditis, with general sepsis, pyaemia and death.

Case VIII. Tonsillitis during puerpera. A married lady of about 24, mother of child two days old, attacked with tonsillitis with diphtheritic appearances. Laboratory examination of the secretions from the throat was made and declared to be a streptococcic infection. Tonsils were exceedingly red and inflamed; hyperpyrexia, followed by sharp attack of endocarditis, enlarged cervical glands, inflamed tendons and muscles. The attack lasted about four weeks, followed by slow and imperfect convalescence. Eight weeks from the time of the first attack patient came to the shore and two days after was attacked by a second severe inflammation of the tonsils. This was likewise followed by secondary enlargement of the glands, with articular pains, tenderness and swelling. Laboratory examination of the secretion from the tonsils showed this attack also to be of streptococcic origin. The remarkable and pleasant feature of this case was its very rapid subsidence under the anti-streptococcic serum treatment.

Case IX. A tonsillitis with some clinical evidence of a coccic infection, in a married woman 40 years of age; a neurasthenic of a hysterical type, accompanied by albuminuria with marked adenitis, especially of the cervical and submaxillary glands. Specimens taken from the tonsils for laboratory examination showed a large number of streptococci. Acute nephritis quickly followed, which subsequently cleared up, leaving a normal and apparently healthy condition.

Case X. Miss S., American, age 26 years, family history good, never sick.

First seen May 6, 1906, giving history of having had tonsillitis five days before, with high fever and pains over whole body. On examination, pulse was found to be 100, temperature 104.4, tonsils very much enlarged and inflamed; heart showed marked endocarditis. There were general muscular and joint pains. Urine showed many granular, hyaline and blood casts, with 15 per cent. albumin. Temperature persisted at 104 for five days with marked delirium; then dropped to 101; pulse between 70 and 80. Delirium, heart and kidneys remained about the same. Pain somewhat subsided. After four days more, temperature reduced to 100; pulse varied between 70 and 80; general condition showed improvement. After three days, temperature reduced to 99, with pulse varying between 50 and 60. This continued for two days, when temperature became normal, and pulse varied between 42 and 50. Heart showed improvement as to sounds; delirium ceased, urine was negative. This low pulse rate continued for eight days, when there began a gradual increase in rate which reached 68 in seven days.

The following abstracts are taken from the current American and foreign literature:

Guring (Munch. Med. Woch., No. 47, '04) calls attention to the relationship between tonsillitis and acute articular rheumatism. In 17 cases of acute rheumatism he noted evidence of tonsillitis in 13, while in the other 4 there was peritonsillar abscess. The tonsillitis noted was chronic, with the formation of yellowish-white plugs of an unpleasant odor. Guring believes that the virus of rheumatism sets up an acute tonsillitis, which may not be especially noted by the patient. The virus remains latent, but virulent, and alone or with other agents, sets up a chronic follicular angina with or without the formation of cheesy plugs. This follicular tonsillitis is at the bottom of many cases of rheumatism which should be prevented by cauterization or excision of all or part of the tonsil. Hewless (Infection and Immunity, page 185) says: "Tonsillar disease appears to play an important role in predisposing to infections with the pathogenic cocci. The wandering of the leucocytes through the epithelium of the tonsils and the frequent local lesions render them especially permeable to bacteria and liable to be the gateway which admits a general invasion of micro-organisms." Hans Weber (Munchener med. Wochenschrift, 1902, No. 52) reports a very curious relation between abscess of the tonsil and appendicitis. There were three cases of angina

tonsillitis immediately followed by acute appendicitis and Weber conceives that the infected material was swallowed, and reaching the appendix, set up inflammation there. Similar cases have been reported previously.

Dr. F. A. Packard, of Philadelphia, in 1900, read a paper at the meeting of the Association of American Physicians in which he reported five cases of endocarditis, each apparently a consequence of an attack of tonsillitis and in two of the cases it was certain that prior to the attack of tonsillitis the heart had been sound, and it was presumably sound in the other three instances. Dr. Julius Eross (*Wiener medizinische Presse*, '98, No. 8) calls attention to the fact that follicular tonsillitis is occasionally met with in the new born. He observed 22 cases. May occur as early as the second day of life. Probably an affection frequently overlooked. Lawson (*British Medical Journal*) reports an interesting case of rheumatic manifestations occurring in two people living in intimate contact. A boy, after bathing, developed tonsillitis, followed by arthritis of many joints, and endocarditis. Ten days later a woman sleeping in an adjoining bed had acute rheumatism followed by endocarditis. Fussell, Jopson and Taylor (*Philadelphia Medical Journal*, January 7, 1899) in a study of 57 cases of leukemia gathered from the literature, say that exudation upon the tonsils occurs frequently enough to make it a possible symptom.

Ullman (*Med. News*, Vol. I, xxviii, No. 4) has reviewed very carefully the literature bearing on the function of the tonsil and of the role it plays as an avenue for infection. It is probable that the normal tonsil has a physiological function of a protective nature, and that infection only occurs through this channel when the tonsil is diseased. Because of its irregularity and of its contour, it affords a place of lodgment for bacteria, to which, through air and food, it is constantly exposed. The denudation of epithelium from the surface of the tonsil also removes the only safe barrier, as the mononuclear leucocytes which are forming in the tonsil have very little phagocytic action. Once the organisms have invaded the gland, its rich lymphatic and vascular supply favor the distribution to other parts of the body. There is reason to believe that through this portal of entry many grave and fatal infections occur, as, for example, acute articular rheumatism, endocarditis, scarlet fever, tuberculosis and possibly those

rare cases of typhoid fever in which no intestinal ulceration can be demonstrated. The similarity of the tonsillar tissues to Peyer's patches suggested to Ullman that the portal of entry of Eberth's bacillus is in the tonsil. He also believes that cases of pyemia, septicemia and septico-pyemia may arise in a similar manner. Jessen (*Munch. Med. Wochenschrift*, June 7, '98) reported two other cases of great interest in which acute septic mischief appeared to have gained an entrance through the faucial tonsils: 1. A woman, aged 28 years, was admitted into the hospital in a comatose condition, and died in 12 hours. The cause of death was ascertained to be pyemia and no other entrance of the infection could be found save through the tonsils, in which suppurative foci existed, and, as these simple abscesses appeared to be older than similar processes in some of the other organs, they appeared to indicate the source of general infection. 2. A girl, aged 13 years, suffered from an angina of the left tonsil, from which streptococci were obtained; there followed upon this pneumonia, pleurisy, pericarditis and nephritis, along with other signs of septic mischief. Streptococci were found in the septum and the general infection appeared to have gained admission through the tonsils. 3. A third and somewhat similar case originating in a tonsillar inflammation is also recorded and here staphylococci were found in all the diseased organs.

The occurrence of remote diseases arising from tonsillar infection is the subject of an important article by Forcheimer (*Archives of Pediatrics*, Sept. 1902). That the tonsils may be the primary site of infection, producing lesions in remote parts, has been known for some time. The paradigm is diphtheria, which has always been accepted by a certain number of authors as primarily a local infection—a fact which has been verified by bacteriological research. Erysipelas, in some instances, has been mentioned, and undoubtedly does occur as a primary tonsillar erysipelas. Baumgarten referred to the tonsils as a possible entrance place of tuberculosis, a fact which has been fully verified by Friedman, the latter author claiming that in young children, especially, it is the site of primary lesion due to food infection. Leyden, Meyer and Singer have shown that the tonsils are first infected in articular rheumatism; and Menzer has demonstrated the presence of streptococci in the peri-tonsillar tissue in this disease. Menzer has also shown that the same organism has been found in the tonsil that has been ex-

cised from a case of erythema nodosum. He expresses the belief that a large number of infectious diseases—pneumonia, scarlatina, measles—the primary infection takes place in the tonsils. The special object of Forchheimer is to call attention to the possibility of infection through the tonsils of two pathological conditions. The first of these is general infection. He believes that it is proper to conclude that if one bacterium is taken up by the tonsils, others also may enter. This is accepted for diphtheria; it has been accepted for tuberculosis and pus producers have been found. The second class of cases considered are those in which jaundice follows an infection of the tonsils. Several cases are reported by Forchheimer which he believes were due to this cause. Numerous authorities are also reported as holding similar views.

The paper by Dr. Thomas Darlington, of New York, at last evening's session, was full of interest, but if in one instance more than in another, it was in the fact that actual data, carefully prepared, announced the very astounding fact that in 70,065 cases examined in the public schools of that city, there were found 27,482 with the cervical glands enlarged, a fraction more than one-third of the whole number, and 13,411 with actual hypertrophied tonsils; or more than one-sixth of the entire school population have an ever present and constant menace to their health and future development, and when compared with the number of cases that were found actually ill of disease, of which there were 50,913 of the total number, or nearly two-thirds of all who were in attendance at school, we find that within a fraction of one-quarter of those ill had hypertrophied tonsils. The figures exhibited by Dr. Darlington's charts emphasize more than words from me, reasons for serious attention being directed to the tonsils in disease. The following deductions, which are the reasonable forecasts from the foregoing discussions, are:

First—General infections or systemic disease unquestionably at times begin in the tonsils. Second—Tonsillar diseases are frequently followed by serious and even fatal invasions of other organs in the body. Third—The existing tonsillar disease, whether apparently simple or severe, should receive careful attention and in many cases vigorous treatment. Fourth—Careful examination of the patient in all cases of tonsillitis, should be recommended in the interim. Fifth—Following severe angina, a thorough examination of the blood, lymphatic and excretory organs should never be neglected.

DISCUSSION.

Dr. W. Blair Stewart, of Atlantic City. I wish to indorse all that has been said in Dr. Marvel's paper. The peculiar location of the tonsils in the throat render them particularly liable to infection from the air inhaled and the food and drink taken. They are unusually rich in glands and lacunae or follicles which are particularly liable to infection and inflammation when their physiologic functions are lessened. They are surrounded by a chain of lymphatics and glands and take their blood supply from six separate sources. Anatomists tell us that the tonsils are covered with leucocytes or phagocytes as well as a lubricating material. All this suggests that Nature has placed every safeguard possible around these organs as a means of defence against the invasion of disease germs. Let the vital forces and physiologic activities of these organs be depressed and an infection is most liable in the form of tonsillitis, quinsy, diphtheria, cervical adenitis and many other troubles.

Nothnagel ("American Reprint on Erysipelas," page 461), in writing upon the subject of erysipelas, quotes cases in support of the theory of the tonsillar route of infection. It is my desire to report to the Society one case in particular of erysipelas which I am convinced gained entrance through the tonsils. Andy K. (aged 40) developed a typical tonsillitis of the follicular type that was soon followed by a discharge from and a rash on the end of the nose. The tonsils were swollen and the lymphatic glandular chain enlarged decidedly before the rash appeared. The rash spread from the nose to the cheek, face, head, neck and mouth and ran the true course of erysipelas followed by suppuration. The photographs presented show the typical conditions present. The infection was undoubtedly of tonsillar origin as there was no surgical lesion on any part of the body to afford entrance to the germ. One of the so-called idiopathic cases with a tonsillar infection to afford a focus from which it spread. Diphtheria is so typical of tonsillar infection that there is little room for doubt. Rheumatism, which is a true infection, undoubtedly bears a very close relation to the tonsillar route of infection. Many cases could be cited to support this hypothesis. The critical bacteriologist will demand that we prove our ground by Koch's laws. While this may be done in some instances our clinical experience and the train of symptoms undoubtedly point to the tonsillar route of infection only. Some recent writers of prominence are prone to ridicule this theory of tonsillar infection but their arguments do not seem to be in the least convincing, while most of them are theoretical—indeed, our hypothesis seems to be founded upon the stronger points of clinical experience. The greatest lesson to be learned from this paper is that our duty to attend closely to the hygiene and physiologic activities of the tonsils and see to it that they receive proper care.

Do not consider too lightly a history of "growing pains" in the extremities in children. These symptoms may be due to a grave osteomyelitis.—*Amer. Jour. of Surgery.*

Reports from the Counties.

CUMBERLAND COUNTY.

S. M. Wilson, M. D., Reporter.

The semi-annual meeting of the Cumberland County Medical Society was held on Tuesday, October 9, in Bridgeton, at the City Hotel. There was a good attendance, and the interest of the meeting was in excess of the ordinary.

The papers read were by Dr. C. M. Wilson, of Vineland, on "The Repair of Cervical and Perineal Lacerations," and Dr. Theodore Eick, of the Philadelphia Polyclinic, on "Uterine Hemorrhage." The papers were both of special interest and elicited general discussion.

Dr. E. S. Fogg, of Bridgeton, reported on the progress of surgery, dwelling especially on inflammation of the inner ear and of acute peritonitis.

Resolutions of regret were offered regarding the death of Dr. David R. Streets, who died suddenly in July. Dr. Streets was elected to membership at the previous quarterly meeting of the Society, and within a few days thereafter, entering his office, after making several professional visits, was suddenly stricken and died from an affection of the heart.

The sympathy of the society was expressed, by resolutions, to the family of Dr. Henry W. Elmer, on account of the serious illness from which the doctor has suffered for the past year and a half.

The treasurer, Dr. Joseph Tomlinson, had been temporarily indisposed, and was necessarily absent from the meeting. A telephonic message of sympathy was transmitted to him.

An interesting paper on "Experience of Practice in India" was read by Dr. E. S. Corson.

Dr. E. J. Chapman, of Shiloh, was elected a member of the society. Drs. W. T. Good, F. F. Corson, and M. F. Sewall were present as invited guests. After the morning session a sumptuous dinner, such as Mine Host Paullin is noted for, was fully enjoyed. At about 4 o'clock adjournment was had, after the selection of Millville as the place of the next meeting in January.

Bridgeton, N. J., Nov. 12, 1906.

MERCER COUNTY.

Charles H. Mitchell, M. D., Reporter.

The members of the Mercer County Medical Society held their annual banquet in the colonial room of the Trenton House on Tuesday evening, November 13th. Dr. J. Chalmers Da Costa, professor of surgery in the Jefferson Medical College, Philadelphia, was scheduled to give a lecture to the society on "A Review of Surgical Tuberculosis," but was unavoidably detained in Philadelphia, much to the regret of the local physicians. His position was ably filled by a former Trentonian, Dr. James K. Young of the University of Pennsylvania, who gave us a most interesting and instructive talk on the same subject.

After enjoying an elaborate menu, toasts under the direction of the Vice-President, Dr. David F. Weeks, were responded to by the following: "Our Society," one that we are making an effort to rank second to none, was taken care of by Dr. David F. Weeks; "Retrospect" was ably handled by Dr. William A. Clark; "The Country Doctor" was dispensed by our rural friend, Dr. Theodore A. Pierson; Dr. George H. Parker, an expert on

repairing balking automobiles, elaborated on the subject, "The Physician's Spark Plug," or the greasy auto versus the horse.

Among the most interesting remarks of the evening were those presented by the present sheriff of Mercer County, Dr. William L. Wilbur. He very dexterously handled the toast, "The Doctor in Politics," and clearly demonstrated the total absence of "graft" in all political positions held down by physicians. Dr. H. B. Costill displayed most excellent taste in responding to "Our Reward."

Dr. Elmer Barwis, on invitation, made some appropriate and entertaining remarks. The evening's entertainment closed with some very appropriate remarks by Dr. William Elmer. The members are of the opinion that the dinner was one of the most successful ever held by the society.

Contract Medical Practice.—The Orange Practitioners' Society at its last meeting adopted the following resolution, and incorporated it as a by-law of the Society:

Resolved, That no member of this Society shall accept or maintain the position of club, society, or organization physician, or do, or agree to do, any medical or surgical work for any club, society, or organization at a less rate than the regular customary charges for like service rendered by other physicians for patients not members of such club, society or organization. Also that in no case shall any physician agree to attend the families of the members of such club, society or organization at half price, or less price than the usual rate.

Nothing in this resolution shall be construed as preventing any member from attending the worthy poor at a less rate, or from giving free service to those who are too poor to pay anything, or from acting as city, county, or town physician, or health officers, or from serving under any political appointments. Any violation of this by-law shall be considered unprofessional conduct, and shall render the member guilty thereof liable to suspension or expulsion from this Society, as the Society may determine.

Free Dispensary Opened.—A new dispensary for the free treatment of the poor of Newark was opened November 1. It is known as the Newark Polyclinic and is under the charge of the following staff: Drs. Siegfried Husserl, S. H. Gordon, Carl F. W. Lippe, E. Reissman, William D. Bleick, Theodore E. Bleick and Charles A. Rosenwasser. It is open to the public every afternoon and evening except Sundays and holidays.

Society Meetings.—At the annual meeting of the East Monmouth Practitioners' Society, at Long Branch, Dr. Harry E. Shaw was elected president; Dr. James J. Reed, vice-president; Dr. Harry B. Slocum, secretary, and Dr. William K. Campbell, treasurer. At the thirteenth annual meeting and dinner of the Clinical Society of the Elizabeth General Hospital, held October 16, Dr. S. J. Keefe, Elizabeth, was elected president; Dr. James L. Perkins, Cranford, vice-president; Dr. Russell A. Shirrefs, Elizabeth, secretary, and Dr. Fred H. Pierson, Elizabeth, treasurer.

If a swelling is "fluctuating" do not be too sure that it is not a solid growth. Lymphangiomata fluctuate.—*Amer. Jour. of Surgery.*

THE JOURNAL

OF THE

Medical Society of New Jersey.

DECEMBER, 1906.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any one failing to get the paper promptly will confer a favor upon the Publication Committee by notifying them of the fact.

All communications relating to the JOURNAL should be addressed to the Committee on Publication, 95 Essex Avenue, Orange, N. J.

LIFE INSURANCE COMPANIES THAT ARE NOT SEEKING CHEAP MEDICAL EXAMINERS.

We herewith publish a list of the life insurance companies paying a \$5 flat fee, as far as known to us. If our readers know of others they will please inform us:

Ætna Life, Hartford, Conn.

American National Insurance Co., Galveston, Texas.

Citizens Life, Louisville, Ky.

Capital Life, Denver, Col.

Fort Worth Life, Fort Worth, Texas.

Manhattan Life, New York City.

Massachusetts Mutual Life, Springfield, Mass.

Mutual Benefit Life, Newark, N. J.

National Life, Montpelier, Vt.

Northwestern Mutual, Milwaukee, Wis.

Pacific Mutual Life, San Francisco, Cal.

Provident Life and Trust, Philadelphia.

Reliance Life, Pittsburg, Pa.

We believe these companies are thoroughly reliable, that they do not pay their officers excessive salaries, and are not mixed up with trusts or political parties. They should be favored in every way possible by the members of the medical profession.

We have erased from the list the Penn Mutual, which pays only \$3, and added the American National Insurance Co., of Galveston, Texas, and the Provident Life and Trust, of Philadelphia, Pa. Dr. Randall, Medical Director of the American National, in a letter stating that the company has adopted the \$5 fee, says: "*It is the desire of*

this company to employ only the best examiners, and they realize they can only get good men by paying a reasonable fee."

That is good common sense and shows that this company is run on sound business principles.

Apropos—We note at the head of an advertisement in one of the State Medical Journals the following: "No Yellow Dog Funds, No Campaign Expenses nor Contributions, No Officers with \$100,000 per year Salary."

PROCLAIMING FINANCIAL PROSPERITY TO THE PUBLIC; PLEADING POVERTY TO THE DOCTOR.

The course of this JOURNAL in reference to the fees paid by the insurance companies for medical examinations was taken after deliberate and very careful consideration of the value of the service rendered and the ethical questions involved. The reasons given by the companies for their action were weighed and believed to be utterly inadequate to justify their treatment of the medical examiners who have served these companies faithfully for many years. The leading argument has been that the companies cannot afford to pay the moderate fee of \$5. That this is utterly groundless will be seen when we consider that the companies which have been largely increasing their enormous surplus every year while paying exorbitant salaries, making political contributions and other grossly improper expenditures, have now, as the result of the investigations, been compelled by law to reduce salaries (though they are still very large), and to cut off the so-called "yellow dog" expenditures. Stopping enormous prodigality and gathering in the millions does not usually tend to poverty. The falsity of this argument will, we believe, also be seen when the annual statements of these companies are issued in January, unless some method is adopted to prevent the showing of enormous profits. Can they, as heretofore, plead for business as they exhibit their great prosperity and wealth of resources while to the doctor they plead poverty? One company we understand has re-

cently adopted the policy of paying the full amount of industrial insurance death claims instead of one-half on policies issued more than six months previous to death. Note the year's profits and amount of surplus. If this surplus belongs to stockholders they certainly have a bonanza and can well afford to divide a small share of the profits with those who have helped them to acquire it. If it belongs to the policyholders the present ones will probably all die before even a small portion of it is distributed, so they will receive comparatively little benefit from it.

This JOURNAL is the official organ of the Medical Society of New Jersey, and in a lesser degree of the County Medical Societies, and it endeavors to represent the medical profession of the State, expressing as far as possible their sentiments, protecting their interests and upholding the dignity and honor of the profession and the high and honorable standing of our State Society. We have received very many communications heartily endorsing our position on this question. We have heard adverse criticism from only one and he is connected with one of the companies. His main argument was that of economy—the companies could not afford to pay \$5. The other arguments were that physicians served benevolent and other organizations for less than the companies paid, and that they supposed that while the older practitioners would not continue to serve at the rates offered, the younger doctors would be willing to do so. To the first argument we have replied; to the second we would say that the insurance company is not a benevolent organization; that such organizations' officers are not paid a salary large or small; that the question is one of adequate compensation for services rendered, not to a benevolent society, but to a wealthy corporation which is steadily adding to an enormous surplus and which is abundantly able to pay at least \$5 for services that require considerable time and critical judgment and for which ten dollars would not be as large in proportion as the president and the medical director receive

for their services. The medical directors know that we are opposed to the cheap fees of benevolent orders as being improper, unprofessional and demoralizing to the profession and harmful to the doctor who thus degrades his high vocation. It is a poor argument that because one benevolent society so treats the physician it is justifiable for a wealthy corporation to take advantage of that to further degrade the profession and keep from the medical examiner what is properly due him. Two wrongs never make a right. To the third argument we reply that the acceptance of *safe* risks only is the basis of sound, reliable insurance, and if inexperienced men are to be selected as examiners *because they are cheap* we strongly advise prospective insurers to avoid the companies that adopt such a policy. *We believe they will soon become unsafe companies.* In some insurance companies experience counts for much and they are willing, for the protection of their policyholders, to pay for it. But again, the service, by whomsoever rendered, is fully worth five dollars and it is unworthy a wealthy corporation to take advantage of the younger practitioners who may need the five dollar fee much more than the older physician. Shame on the insurance company whose stockholders have been made rich by the value of their stock and the enormous dividends thereon, that would take advantage of a young man who is willing to struggle for position in one of the most exacting professions by offering him half pay for services rendered that company.

MEDICAL LEGISLATION.

We print in another column a very important communication from Dr. L. M. Halsey, chairman of our State Society's Committee on Legislation, and we ask that every member of our Society shall give it that careful consideration which its importance demands, and then act upon its suggestions not only as individuals, but in stirring up his County Society to take united and efficient action. The members of the Committee on Legislation, and especially the

chairman, have done most faithful and successful work and the value of the vast amount of thought and time they have freely given cannot be estimated. Our Society and the public owe them a vast debt of gratitude, which can never be paid, but we as members can show our appreciation of their services, by taking from them during the present year a large part of the burden which heretofore they have borne for our and the public's good. To Dr. Halsey's friend who so voluntarily and generously bore the entire expense of the recent visitation of a large number of the members of our County Societies our State Society owes its profound thanks, which will doubtless be fittingly expressed.

We would emphasize what Dr. Halsey says concerning thorough organization and also as to the importance of some method "to instruct the laity on the importance of medical men having a general supervision over medical and sanitary matters, and that their purpose was entirely philanthropic and not at all mercenary." It certainly should need but little argument to convince even the superficial thinker that the medical man is the most competent adviser in such matters and that there can be no mercenary object in a supervision by medical men which will conserve the public health and thereby lessen the doctor's income.

Again we say to every member of our Society: READ, HEED and ACT upon Dr. Halsey's suggestions.

QUARANTINE FOR SMALLPOX.

We notice in the *Journal of the Minnesota State Medical Association* that the Minnesota State Board of Health proposes, after January 1, 1908, to abandon attempts to control smallpox in that State by means of quarantine. We believe that our public health authorities generally will approve this action and would have justified the Board in placing the date one year earlier. The following is the action taken by the Board October 9, 1906:—

It having been established that smallpox

will not spread in a well vaccinated community, and believing that all attempts to restrain smallpox in a community not protected by vaccination, by means of quarantine, will fail; that quarantine in a well vaccinated community is unnecessary; that attempts to control the spread of smallpox by means of quarantine is unscientific, irrational, expensive, and misleading; that in laying down strict rules for the quarantine of smallpox, sanitary authorities are favoring unscientific and illogical methods for its control, and are conveying false ideas as to the safety of the public, the Minnesota State Board of Health advises that after January 1, 1908, further attempts to control smallpox in Minnesota by means of quarantine shall be abandoned.

A few years ago some of us expressed our judgment, as physicians and sanitarians, that this method of controlling smallpox was inexpedient and unnecessary, that it put an *improper* restraint on personal liberty, was not the best way to control the disease, and because it was not the most effectual way to prevent its spread, it placed an unnecessary burden on a community because of its great cost. Time, however, has changed the opinion of many who took us to task for thus expressing our judgment, and the general consensus of opinion now favors the abandonment of quarantine for the control of smallpox.

The Board of Health of the State of New Jersey declared, Circular 104, issued in August, 1902:—

Domestic quarantine is always unreliable, and an outbreak of smallpox cannot with certainty be arrested unless a suitably-located and properly-conducted isolation hospital is provided by the municipality or township. Guards for preventing communication with patients who are confined in private houses cannot be depended upon to perform their duties effectively, and, indeed, they often serve as carriers of the infection to other persons.

The isolation hospital is to be commended and many of our cities have wisely provided them, but the public should be taught that of all communicable diseases there are none which can be controlled so absolutely as smallpox, and that the one means of control that is thorough and effectual is vaccination. Let us have compulsory vaccination. Meanwhile, if our friends—the anti-vaccinationists—persist in rejecting this—the only safeguard against smallpox—they should bear the burden of an epidemic that their ignorance or wilfulness permits.

SECOND-CLASS MAIL AND THE POSTAL DEFICIT.

The proposed increase of charges on second-class mail matter from one to four cents per pound is a grossly unjust proposition, because it lays heavy burdens unnecessarily upon those agencies that are doing a vast amount of work for the education of the people and the advancement of science, while continuing the unjustifiable policy of paying the railroads exorbitant charges for the transportation of the mails.

The rural delivery system has greatly increased the expenses of our postal service, but it is for the benefit of the rural population and for many reasons we heartily approve it. The burden, however, of its maintenance should not be put upon the users of second-class mail, and it need not be if other expenses of the post-office department were properly adjusted.

The amount paid the railroads for carrying the mails last year was \$39,384,916, plus \$5,509,044 for rental of postal cars, making a total of nearly \$45,000,000. The Postmaster General, in his report, December 5, 1905, referring to the increasingly large amount paid to railroad companies for transportation of mails, said, "Correspondence on file in the Department, as well as frequent references in the public press, indicate that there is a widespread popular belief that this pay is extravagant." The railways charge the government, according to Postmaster General Wilson, 8 cents a pound for hauling second-class matter, but haul the same stuff for the express companies for about the tenth of a cent per pound.

Frank Parsons, Esq., a prominent member of the Boston Bar, says, "If the railways received no more from the post-office for carrying the mails than they would receive if they were carrying the same matter for the express companies, the post-office would save twenty-five to thirty millions of the forty-five millions it now pays the roads."

We give only two of the many instances he cites—the relation between mail and ex-

press for the route from New York to Buffalo, 439 miles, New York Central Railroad: railway earnings per year for 125 tons of *mail* daily, \$1,447,840; railway earnings per year for 125 tons of *express* daily, \$436,250, and the former does not include the receipts for postal car rentals. Mr. Parsons also shows that the railways receive:—

For carrying the mails, 27 cents per ton-mile.
For carrying express generally, 3 to 6 cents per ton-mile.

For carrying excess baggage, 5 to 6 cents per ton-mile.

For carrying commutation passengers, 6 cents per ton-mile.

For carrying dairy freight (as low as) 1 cent per ton-mile.

For carrying ordinary freight, 2 cents per ton-mile.

For carrying imported goods, New Orleans to San Francisco, .8 of a cent per ton-mile.

For carrying average of all freight, .78 of a cent per ton-mile.

The mail rate should certainly not be more than from 3 to 5 cents. There is no expense for storage, loading and unloading as in express or excess baggage, it is easily handled, and there are no station expenses—practically nothing but the cost of hauling.

We have considered only one matter—the excessive cost of post-office expenses as mainly chargeable for the deficit. There are others we will not enlarge upon, e. g., the cost of the franking system—with probably thousands of tons of printed matter sent throughout the country that is consigned to the waste-basket without being read.

If there is necessity for increased rates on second-class matter why advance that item 300 per cent. and continue the exorbitant pay to the railroads. Again we ask should there not be a fair and just discrimination if an advance must be made, between the journals, magazines, etc., which are published by money-making concerns and those that are issued purely for the advancement of science, by societies that have difficulty in meeting the expense or issue them at a loss. The 300 per cent. in postal rates is a very heavy burden on the latter class of publishers. It possibly means \$100 increase in the cost of our JOURNAL.

We urge our members to expostulate

with our Senators and Representatives in Congress against this unjust proposition.

We never wish to be hypercritical but we believe we have good reason for our conviction—that there would be a profit rather than a deficit, even at present rates, if our postal service were conducted according to strict business principles.

The thirty-second annual meeting of the New Jersey Sanitary Association, held at Lakewood, November 16 and 17, was more largely attended than usual and the papers and discussions were generally above the average. They were on practical subjects that are worthy the consideration and study of the members of our profession as well as of the non-medical sanitarians. An unusually large number were added to the membership, mainly physicians. The following officers were elected for the ensuing year: Gordon K. Dickinson, M. D., Jersey City, president; John B. Duncklee, C. E., South Orange, first vice-president; William G. Shaufler, M. D., Lakewood, second vice-president; Rudolph Hering, C. E., Montclair, third vice-president; James A. Exton, M. D., Arlington, secretary; George P. Olcott, C. E., East Orange, treasurer; Edward Guion, M. D., Atlantic City, chairman executive council. Drs. D. E. English, W. H. Shippo, T. W. Harvey, H. C. H. Herold, A. C. Hunt, B. V. D. Hedges, R. H. Parsons, T. N. Gray, G. E. McLaughlin, H. H. Davis, F. D. Gray, J. Tomlinson, of our State Medical Society, are members of the executive council, besides the honorary members—Ex-presidents, Drs. W. K. Newton, Henry Mitchell, D. Benjamin, David C. English, Daniel Strock, John L. Leal and Norton L. Wilson. Some of the papers presented at this meeting we shall print in later issues of *THE JOURNAL*.

The New Jersey Association for the Prevention and Relief of Tuberculosis is doing excellent work in organizing local associations and educating the people on this subject, showing them the nature and prevalence of the disease, that it is communicable, preventable and curable; that it is possible

eventually to banish it from our midst as completely as cholera has been banished, and arousing them to intelligent and effective action for its eradication.

The Association's programme is: (a) To organize local committees in cities and towns throughout the State; (b) Through these committees, and directly, to deliver lectures in churches, clubs, private parlors, and before organizations and institutions; (c) To distribute circulars of instruction in schools, department stores, shops, factories, and in homes where consumption is found; (d) To procure the establishment of dispensaries which shall give direct physical and bacteriological examinations, and adequate advice; (e) To provide registration, instruction, and nursing, as far as possible, for all indigent consumptives reported; (f) To secure special diet for all consumptives not able to afford the same; (g) To secure, through local Boards of Health, registration of all consumptives; (h) To promote the establishment of sanatoria where consumptives may be received at moderate charges; (i) To procure disinfection of all rooms in which consumptives have died; (j) To prepare an educational Tuberculosis Exhibit, illustrating methods of open air and indoor treatment in the prevention and cure of consumption.

Mr. William C. Smallwood, of Newark, is the Executive Secretary. In the next issue of *THE JOURNAL* we hope to give a fuller account of the organization and its work.

In the September 15th issue of *The Councilor's Bulletin*, published by the American Medical Association, is quoted as a "Pertinent paragraph," the following from the Crawford County, Illinois, Medical Society announcement, which we commend to the thoughtful consideration of every physician who is not actuated by purely selfish motives, but is capable of recognizing his relations and obligations to his medical brethren and his responsibility to the public: "The man who does not attend the meeting of his county medical society should be classed with the quacks. If he is above the average he should give the society the benefit of his wisdom. If he is below he should go and learn. If you have a good idea, bring it with you. If you have a fallacy the sooner you get it knocked out of you the better for suffering humanity. The public would do better to inquire: 'Do you attend the meetings of your county medical society?' than 'Where did you graduate?'"

Correspondence.

From the Committee on Legislation, Luther

M. Halsey, M. D. Chairman.

Williamstown, N. J., Nov. 23, 1906.

Dear Mr. Editor:—

You ask for something from the Legislative Committee. If the suggestions of this committee have been partially carried out the work is done; we are on good, substantial ground. We will have the votes at the next session of the Legislature that will be overwhelmingly for such measures as we approve, and they will be strongly against those that we do not favor. We have asked you to organize, to bring in new members, to interview prospective candidates for the Legislature as to their standing on matters in which we were interested. Through the generosity of a friend of the Medical Society of New Jersey, I had a representative visit every County Medical Society in the State, urging organization, securing new members, finding the status of prospective candidates, and insisting that County Societies should take some steps to instruct the laity on the importance of medical men having a general supervision over medical and sanitary matters, and that their purpose was entirely philanthropic and not at all mercenary. I have asked through the Journal a pledge of the members that they would only support such men for the Legislature as would stand for the uplifting of medical and sanitary measures beyond common politics.

The entire expense of sending a man to visit the members of the County Societies was contributed by a friend of mine. It did not cost the Medical Society of New Jersey one penny. Yet we are confronted with the statements so frequently that this and that County Society are so indifferent, it is almost impossible to get the members to do anything to organize and bring pressure to bear upon Legislatures. Several counties deserve to be highly commended; they have done most excellent work and their status is all that could be desired.

My representative in visiting the counties of the State personally asked members to give me certain information. Only three or four counties in the entire State responded. If the medical profession do not want osteopathy to be licensed, if they do not desire vicious legislation enacted, they must cast aside selfish motives for a time, cease to be laggards, and do some things to help your Legislative Committee.

We are very desirous that Dr. Haines should be on the Committee of Public Health of the Assembly. Let each County Society bring all the pressure they can to accomplish this. Interview the members of the Legislature and write the Chairman of this Committee as soon as possible what they will probably do: First, as regards osteopathy; second, pure food and pure drugs and a nostrum bill. Let each individual member pledge that he will do something. We should work to procure suitable State laws, to secure ample accommodations for the consumptive and insane poor, and to remove the dense clouds of ignorance which so effectually retard the progress of medicine and sanitation. Organization means progress, not alone of the individual member, but of the profession, for by organization the profession gains weight, influence, dignity and honor.

We are lacking in public instruction and the medical profession will fail to meet its responsibility if we do not earnestly pledge ourselves to do this work. We did fairly well last year; let us all determine that our work this year shall be that of one united body, working for the public good, and thereby for the upbuilding of our noble profession.

Yours very sincerely,

L. M. HALSEY,
Chairman.

ON MEDICAL EXAMINERS' FEES.

The following are copies of two letters sent to the Medical Directors of insurance companies in reply to letters notifying of reduction of the fee from \$5 to \$3. The first one was sent to the Equitable Life Assurance Society and the other to the Union Mutual of Portland, Maine, Medical Directors:

NEW BRUNSWICK, N. J., Sept. 26, 1906.

Dear Doctor:

I acknowledge the receipt of your letter and the accompanying circular. Have given the latter careful thought and reply to some of its arguments.

From its general tenor I have been led to question whether I care to act longer as a medical examiner and, after some reflection, I hereby offer my resignation after more than thirty years of service.

The officers and agents of the company are most liberally paid. The discrimination is against the medical examiner, and, strange to say, after attempts I have made to ascertain who is responsible, this circular seems to place responsibility on the medical department. Why should the medical examiner's fee be determined by what he receives for office calls or visits on his patients? Is it a fair, just basis? Would the medical director consider it so if applied to him and would he be pleased to have his salary reduced in this sudden spasm of economy, while the company is adding constantly to their enormous surplus? And why does not the same line of argument apply to the agents? From my long experience as an examiner, I believe not one-half would earn in other business more than 60 per cent. of what the insurance companies are paying them, but *I do not believe they are overpaid*. But the item I most disliked, which seems to me very like a threat, is the concluding paragraph. A prominent insurance officer said to me, after I read it to him, "Why the doing away with medical examinations is perfectly absurd."

Another point—that the company has to pay for many examinations in cases where the policy does not issue and therefore cannot afford to pay the \$5 fee! How then is it—if information that has recently come to me is true—that the company has authorized some of its agents to write up every man apparently insurable who is willing to be examined and the company will take the chance of placing the insurance, relieving the agents of the cost of the examiner's fee when the policy is not taken—the company paying the fees?

I appeal to your sense of justice; *this action is not just*. The physician is called upon to give an immense amount of charity to private patients who are not able to pay, and free service in hospitals, dispensaries, etc., and this is cheerfully given (his charity, however, in connection with these institutions is often imposed upon by

those able to pay); then comes in the contract system which is another imposition. We submit that when insurance companies with enormous surpluses, paying enormous salaries, cut down their medical examiners' fees, "patience ceases to be a virtue," and it is justifiable to call it intolerable and to express "righteous indignation."

Yours very truly,

D. C. ENGLISH.

TRENTON, N. J., Nov. 21, 1906.

Edwin M. Northcott, M. D.

Medical Director, &c.

Dear Sir: Your circular letter in reference to a \$3 fee for medical examinations is at hand. I absolutely decline to accept it, and am very greatly amazed that your company should so belittle and degrade itself as to request it of any respectable or self-respecting physician.

You rely upon your examiners to protect your company from thousands of dollars worth of bad risks. They are the men whom you most trust for guarding against heavy losses, and yet, while requiring the best skill and greatest care, you cut their fee down to "cheap John" prices. For the reflective consideration of yourself and your board of directors, I send you the enclosed leaves, from the New Jersey Medical Society Journal, for the current month.

You can either pay my full fee of \$5. or take my name off your list of examiners. I do not think you will get any physician in Trenton to act as examiner at that reduced rate.

Yours very truly,

WILLIAM ELMER.

An Insurance Examination is Well Worth \$5.—This service requires the highest degree of scientific information and practical judgment—a knowledge of all the organs of the body and their examination in health and disease, together with a careful weighing of past illness, family history, and present conditions as affecting longevity, to reach a final judgment worthy of influencing large investments.

This service is not only exacting but commonly emergency work, done at sudden notice, at irregular times and various places. It is often followed by most inconvenient supplementary questions and re-examinations, and demands more ample reward than a mere routine service.

A veterinarian would rightfully charge \$10 for thoroughly examining heart, lungs, limbs, eyesight and gait of a \$300 horse for a would-be purchaser. The directors of life insurance companies must be ignorant of professional ability who declare \$3.00 to be sufficient for an examination and opinion of human life worthy a three-thousand-dollar investment.

Twenty years ago, the majority of the companies paid \$5.00. Since then the demands on physicians have increased. Medical schools have extended their curricula from two to four years; reading and writing were then the only preliminary educational requirements; now these requirements embrace a full high school course. A dollar would then buy twice as many necessities of life as at present. The wages of the other vocations have many times increased. Physicians must have increased rather than diminished compensation to enable them to do the best possible work for humanity.

The companies can pay \$5, the physician earns it, policyholders are safer when it is paid. For these reasons the medical profession of the State of Texas requests and insists that a fee of \$5 be established by all Old Line Life Insurance companies doing business in the State.—Texas State Journal of Medicine.

Osteopathy and Smallpox.—I find there are quite a few osteopaths on our subscription list. And several of them asked me what I thought of osteopathy. Well, I'll tell you frankly. Like every system which ascribes all diseases to one etiologic factor, or which treats all diseases by one method, it is rotten. There you have my frank opinion. This does not mean to assert that osteopathy may not prove very useful in certain indicated cases; it may even cure a small percentage in which regular medicine fails. But this does not change the fact, that on the whole, like every sectarian system, it may do much more damage than good. You must first learn to diagnose your cases. There can be no intelligent therapy without at least an approximately correct diagnosis. And osteopaths are not diagnosticians. In this connection the following editorial from the *Medical Fortnightly* of St. Louis (Aug. 26), is quite interesting:

"A good story comes from the City Dispensary, which demonstrates the wisdom behind osteopathy. A lady phoned the dispensary that she wished a physician to call and examine two 'doctors' who were suffering from a suspicious eruption. The dispensary physician responded and found two osteopaths with an eruption so obvious that it was quite beyond 'suspicion.' Questioning developed that they had been treating a child for such an eruption which they had diagnosed as due to a 'luxation of one of the dorsal vertebra.' Investigation showed that the child and its 'doctors' had the smallpox, and they were sent to quarantine. It is safe to say that these osteopaths will hereafter have a belief in something other than dislocation when they see this form of eruption, but what of the community while others are learning the same lesson?"

This story would be purely amusing, if the contemplation of the dangers to which patients of the various quacks are subjected, did not incline one to sadness.

Crusade Against Uncleaness.—The Massachusetts Board of Health, after finishing its active crusade against unclean dairies, foul ice-cream manufactories and unfit meat supplies in the various cities and towns of the State, has entered on a study of bakeries and found 247 "distinctly bad," 235 "not especially bad," 41 "satisfactory," and only 12 "worthy of special commendation."

Celebration of an Historic Event.—"Ether Day" was celebrated October 16 at the Massachusetts General Hospital, being the sixtieth anniversary of the performance of the first operation under ether at that hospital.

Will Prosecute Illegal Practitioners.—The Michigan State Board of Registration is taking active measures to prosecute physicians who are practicing without being registered, and others legally registered but who are guilty of unprofessional conduct.

Current Medical Literature Items.

The Open-Air Treatment of Pneumonia.—W. P. Northrup for over eleven years has been using free ventilation and fresh air treatment in pneumonia. The patients most favorably affected by open-air treatment are those with severe poisoning, with delirium, partial cyanosis, or deep stupor. In Northrup's experience all patients do better in cool fresh air, which can be secured in private practise by screening off a portion of a room by an open window. None have been harmed, in his observation, and some have been greatly benefited and possibly saved by the cold fresh-air treatment. If pneumonia, due to an infecting agent, is thus benefited, the value of the treatment for other infectious diseases is suggested, and, in fact, he has tried it in many others, including typhoid fever with severe bronchitis, whooping-cough with bronchitis and convulsions, with excellent results. He considers it, in fact, the ideal treatment for septic fevers. The only regulation is to keep the patient comfortable and especially to keep the feet warm.—*N. Y. Med. Record*.

The Sedimentation of Sputum by Means of Hydrogen Peroxide—Sachs-Mueke (*Muench. med. Wochenschr.*, 1906, No. 34).—If hydrogen peroxide be added to a purulent sputum an active effervescence takes place during which all lumps and masses of pus and tissue are violently torn apart and the sputum converted into a more or less homogeneous mass. Upon being allowed to stand, the sputum separates into three layers; an upper one consisting of froth, a middle clean fluid layer and at the bottom a solid mass consisting of detritus and micro-organisms. In this lower layer, bacteria of all sorts, especially tubercle bacilli, can be found very much more readily than in the original sputum. The addition of one part per thousand of bichloride to the peroxide of hydrogen makes possible a still further extension of the method. If this mixture be placed in a vessel by the side of the patient and the latter directed to expectorate into it, the entire twenty-four hours' amount of sputum may be collected without danger of infection. Whenever it is desired to examine the sputum, the disintegration and sedimentation will usually be found to have taken place and the material at the bottom of the vessel will be suitable for examination.—*Inter-State Med. Jour.*

A New Method of Gastrostomy.—Tavel suggests the following procedure as a means of avoiding many of the inconveniences attending the usual gastrostomy opening. Through a median incision a portion of the jejunum about 15 cm. in length is resected without interfering with its mesenteric attachments. The continuity of the intestine is restored and the distal end of the resected segment is sutured into the stomach opening after having been passed through the mesocolon and omentum as in gastroenterostomy. The proximal end is carried to the surface and is implanted in the abdominal wall, preferably in a separate incision. Tavel has carried this operation out in one case with excellent results, there being no leakage even on coughing or on exer-

tion. The only disadvantage of the plan is the extra time required to carry it out.—*Zentralblatt für Chirurgie*.

Nervous and Mental Disturbances in Alcoholics.—Rybakoff, who has charge of the dispensary for alcoholics connected with the Moscow Psychiatric Clinic, presents a detailed statistical study of six hundred alcoholics with reference to the frequency and forms of nervous and mental disturbances in this class of patients. The great majority of his patients were men. Most of them were habitual drunkards (more than sixty per cent.), a smaller number were periodical drunkards (twenty-five per cent.), and the rest occasional drunkards (five per cent.). In women periodical drunkenness is more frequent than in men. Periodical drunkenness is, according to Rybakoff, an expression of a lower form of degeneration than is habitual drunkenness. Delirium tremens and hallucinations in general are observed in more than one-third of all alcoholics. Hallucinations are more frequent in the periodical drunkards (fifty-seven per cent.) than in habitual alcoholics. Epileptic seizures occur in about ten per cent. of drunkards. They are less frequent in the periodical type than in the habitual, and are due to a chronic poisoning of the cortex. Alcoholic dementia is found in one per cent. of the drunkards studied, and almost exclusively in the habitual type. This dementia is also the effect of chronic alcoholic poisoning. Multiple neuritis is found in about two per cent. of drunkards, and chiefly in habitual drunkards. It is met with in persons who drink large amounts of alcohol. Degenerates show a type of drunkenness, which is between the habitual and the periodical. In them drunkenness is not so much a disease as a manifestation of an abnormal state of the nervous system.—*Roussky Pratch*.

Medical Treatment of Uterine Fibroids.—Lamendean reports (*Le Journal de médecine et de chirurgie*, Montreal, September 8, 1906) an interesting case of a woman, thirty-eight years of age, who suffered with carcinoma of the breast and with uterine fibromyoma. She was very anemic on account of the great loss of blood at her menstrual periods. The breast was removed by Dr. Mercier, but the operation of hysterectomy was deferred for six months on account of her poor general condition. She came under the care of Dr. Lamendean, who gave her tablets of arsenic and strychnine (0.02 gr. ea. after each meal) and 15 or 20 grains of quinine, in one dose, each morning during her menstrual period, and she was directed to remain in bed while the flow continued. After five or six months of treatment she was again examined, and the fibroids were found to have almost entirely disappeared. At this time the menses were regular, there was no longer any pains, and the general condition had greatly improved, so that there was no longer any question of operation.—*N. Y. Medical Journal*.

Conjugal Tuberculosis.—Weinberg's statistics show that widows and widowers, surviving the deaths from tuberculosis of their consorts, suffer from tuberculosis in double the percentage exhibited by the rest of the population. Widows are more frequently affected than widowers, and the proportion is larger in the crowded homes of the poor than among the well-to-do.

Diffuse Peritonitis.—Dr. John B. Murphy, of Chicago, reported at the annual meeting of the Amer. Ass'n of Obstetricians and Gynecologists, 36 cases of general suppurative peritonitis from perforation, with one death. In treating this condition he emphasized the importance of relieving pressure and of instituting drainage, doing as little surgery as possible. The patient should be put in a sitting position both before and after operation, so as to keep the infective material out of the diaphragmatic zone, and not the pelvic zone. At the time of operation the patient usually has all the infection he can carry; he is handicapped, and it is the duty of the surgeon to eliminate that infection or intoxication as much as possible, and in doing so care should be taken not to abrade any more surface so as not to admit more infective material. The patient should be tidied over for a few hours and his local resistance built up by washing out the blood with normal salt solution. Antistreptococcic serum should be employed and little or no food given.—*Journal Amer. Med. Ass'n.*

MONTHLY STATEMENT OF THE BOARD OF HEALTH OF THE STATE OF NEW JERSEY, OCTOBER, 1906.

By David S. South, Registrar of Vital Statistics

Mortality.—The number of deaths reported to the Bureau of Vital Statistics for the month of October, 1906, was 2,519, a decrease of 216 from the previous month, and 719 less than during the month of August. By ages there were 631 deaths among infants under one year, 254 deaths of children over one year and under five years, and 600 deaths of persons aged 60 years and over. As usual at this season of the year the number of deaths from infantile diarrhoea is diminishing, the mortality from this cause for October (237) being only forty-five per cent. of that for September (520). Pulmonary tuberculosis continues to maintain a high death rate (257), but a falling off is shown in the figures for pneumonia (100). The number of deaths from the group of affections which is classified as "diseases of the nervous system" (313) is sixty-three less than the average for the months of July and August. The usual annual increase in the deaths from typhoid fever has not yet appeared in the records, and the figures for July (24), August (28), September (29) and October (27) vary but little. Scarlet fever caused only three deaths, and only two were caused by measles, but the mortality from whooping cough was forty-two.

The following table shows the number of certificates of death received in the State Bureau of Vital Statistics during the month of October, 1906, and also the number of deaths from certain selected causes. Causes of death and number of certificates received: Typhoid fever, 27; measles, 2; scarlet fever, 3; whooping cough, 42; diphtheria and croup, 47; malarial fever, 3; tuberculosis of lungs, 257; tuberculosis of other organs, 47; cancer, 106; cerebro-spinal meningitis, 22; disease of nervous system, 313; disease of circulatory system, 218; disease of respiratory system, (pneumonia excepted), 121; pneumonia, 100; infantile diarrhoea, 237; disease of digestive system (infantile diarrhoea excepted), 225; Bright's disease, 166; suicide, 27; all other causes, 556; total, 2,519.

FOODS AND DRUGS.—During the month of October, 1906, 227 specimens were examined under the

direction of the State Board of Health, in the State Laboratory of Hygiene, as follows:

	Number of specimens.	Number above standard.	Number below standard.	Percentage of specimens adulterated.
Milk	132	105	27	20.4
Butter	2	1	1	50.0
Cream	11	7	4	36.5
Maple syrup	1	0	1	100.0
Molasses	2	2	0	0.0
Molasses, compound..	3	3	0	0.0
Oleomargarine	1	1	0	0.0
Olive oil	5	5	0	0.0
Vinegar, cider	1	11	10	47.0
Vinegar, white	1	1	0	0.0
Camphorated oil	5	3	2	40.0
Ether	1	1	0	0.0
Tincture iodine.....	11	1	10	90.9
Tincture opium.....	8	1	7	87.5
Totals	204	142	62	30.3

Number of samples of water analyzed, 23.
BACTERIOLOGICAL EXAMINATIONS FOR DIAGNOSIS.—During the month of October 751 specimens were examined for diagnosis, as follows: From suspected cases of diphtheria, 334; tuberculosis, 245; typhoid fever, 154; malaria, 11; miscellaneous, 7.

PRIZE ESSAY.

This prize was instituted by the Medical Society of New Jersey at the annual meeting in 1905, and is open for competition to the members of the Component (County) Medical Societies.

The subject chosen is "The Symptoms, Etiology, Pathology and Treatment of Pneumonia."

The essays must be signed with an assumed name and have a motto, both of which shall be enclosed in a sealed envelope containing the author's name, residence and component society.

The essay shall contain not more than 4,000 words, and must be characterized by originality in investigation and thought, and by clearness and conciseness of expression, and be, in the judgment of the committee, of decided value to the members of this society, and to the profession generally. Failing in these respects, no award will be made.

The essays, which should be type-written, with the sealed envelope, must be placed in the hands of the committee on or before the first day of May, 1907.

The committee will select the first two essays in order of merit. To the first will be awarded the prize of one hundred dollars, to the second that of honorary mention.

The unsuccessful authors will receive back their essays upon their identification to the chairman of the committee. The successful essay will be the property of the society and be published in its transactions.

CHARLES J. KIPP, Newark, *Chairman.*
WALTER B. JOHNSON, Paterson.
DAVID C. ENGLISH, New Brunswick.
Committee.

Personal.

Dr. Edward E. Haines, of South Amboy, Middlesex County, was re-elected a member of the Assembly, Nov. 6, by about 1,000 majority. He rendered the profession valuable service in the Legislature last winter. **Dr. Waldo F. Sawyer** was elected mayor of Vineland, Nov. 6. **Dr. Eugene J. Asnis** has been appointed a member of the Woodbine Board of Education. **Dr. Leslie L. Hand**, of Millville, has been appointed a pastor of the Newfield Methodist Episcopal Church. **Drs. Henry Mitchell**, of Asbury Park, and **James A. Exton**, of Arlington, are among the physicians from New Jersey in attendance upon the American Public Health Association. **Dr. E. L. B. Godfrey** of Camden has gone to California for the winter.

Married.

Hill-Harris.—In Asbury Park, N. J., October 29th, Dr. John A. Hill and Miss Alice Smith Harris.

Grover-Fiske.—In Somerville, N. J., October 10th, Dr. Arthur Launy Grover and Miss Clara Elizabeth Fiske.

Resseque-Hanson.—In Montclair, N. J., October 24th, Dr. Frederick J. Resseque and Miss Helen J. Hanson.

Deaths.

Felsberg.—In Atlantic City, N. J., October 28th, Dr. Paul Felsberg, aged thirty-seven years.

H.—In Atlantic City, N. J., October 28th, Dr. A. L. Hudder.

Jenkins.—In Plainfield, N. J., November 13th, Dr. Olin L. Jenkins, a former mayor of Plainfield, aged fifty-four years.

Lewis.—In Hudson Heights, N. J., October 17th, Dr. Harry Parker Lewis, aged thirty years.

Selover.—In Newark, N. J., October 16th, Dr. W. Updike Selover, who graduated at the New York University in 1864, practiced many years in Rahway, and later in Newark, aged sixty-three years.

Shafer.—In Camden, N. J., November 8th, Dr. William Shafer, aged fifty years.

A' Heron.—At Hampton Junction, N. J., November 15th, Dr. T. M. A' Heron, who for many years was a surgeon to the Central Railroad of New Jersey, aged sixty years.

Book Review.

DISEASES OF THE DIGESTIVE SYSTEM.

Modern Clinical Medicine Series.

Edited by Frank Billings, M. D., Prof. of Medicine, University of Chicago, Ill. Prof. of Medicine and Dean of Faculty, Rush Medical College, Chicago.

An authorized translation from *Die Deutsche Klinik* under the general editorial supervision of Julius L. Salinger, M. D.

D. Appleton & Co., New York, 1906.

With forty-five illustrations in the text.

Cloth; 824 pp.

During the past few years the diagnosis and treatment of diseases of the digestive tract have been much more satisfactory than formerly because based on a full scientific knowledge, and this is due to the advances of chemistry with the aid that abdominal surgery has afforded. But there are still many problems to be solved which require the careful and patient study of both the general practitioner and the surgeon. Dr. Salinger has rendered the profession great service in giving us this volume, the results of recent scientific investigations. The various subjects are treated by some of the most eminent men of Europe so practically and thoroughly that Dr. Billings, the editor of the American edition, has found little need to add to, or modify the text, and most careful readers of this volume will agree with him that "the diagnosis of the various diseases is fully discussed and the treatment, including the dietary, is satisfactorily full and complete."

While all the articles are valuable, there are two subjects treated on which our former textbooks throw but little light and which are worthy of special consideration—One on diseases of the pancreas, which is ably treated by Dr. Oser, of Vienna, and the other by Dr. Strasburger, of Bonn, on the macroscopic, microscopic, bacteriologic and chemical investigation of the feces in diseases of the intestines. This field of investigation, like that of the sputum and urine, is an important one which has aided, and gives promise of furnishing still more valuable aid, in the diagnosis and treatment of diseases of the intestines.

We commend this volume as a valuable contribution to our knowledge of the organs of digestion and their diseases.

E.

Believing that the matter of the medical examiners' fees affects the welfare of life insurance policyholders, and the rightful claims of the medical profession, it is suggested that the local and county medical societies which hold meetings between this

date and January 25 pass a resolution requesting the President of the Medical Society of New Jersey to appoint a committee of five who shall prepare and issue a statement to the public on this question.

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THE OMENTUM AND ITS FUNCTIONS.*

By Gordon K. Dickinson, M. D.,
Jersey City, N. J.

The concept of the omentum in the minds of most of our writers has been incompletely stated, the anatomist having the most to say in his descriptions of its various folds. Until recent years but few accurate observers have endeavored to describe its structure or numerous functions. A detailed study of this tissue brings to light many researches which give evidence of its great importance in the protection of the peritoneal cavity. It is impossible to discuss this organ apart from the conditions of the general peritoneal surface, nevertheless, owing to its histo-anatomy being somewhat distinctive, its functions are, to a certain extent, unique.

Embryology. By the end of the first month of foetal life the digestive tract is formed, consisting of but a single tube; a dilatation in the upper part of which becomes the future stomach. This dilated portion is situated in the future thoracic cavity; has two attachments, known respectively as the anterior and posterior mesogastros; the posterior curvature becoming more pronounced than the anterior. Just below the stomach, in the third week, a rudimentary liver evaginates into the anterior mesogastrium, and in the fourth week, the pancreas into the posterior. The position of the pancreas and its early attachments to the mesial line determines the fixation of the duodenum, which is the first part of the in-

testinal tract to become fixed. In the meantime the stomach descends toward its future normal position, rotating at the same time, so that what was the posterior border becomes the inferior, and the anterior, the superior. The posterior mesogastrium becomes redundant, out of proportion to the requirements of its visceral connections, and, to some extent, independent of the direct mechanical purpose of carrying blood-vessels to the viscera^a. The growth of the spleen carries the attachment of this membrane to the left. The posterior, or right surface of the mesogastrium forms the cavity which is known as the cavity of the lesser omentum. At, or soon after, birth, there is a cohesion of the posterior layer of the ommental fold with the transverse mesocolon. By this cohesion the pancreas becomes covered and the buried peritoneal surfaces absorbed, areola tissue taking its place. Through this, the transverse colon seemingly becomes a part of the descending layer of the omentum.

Anatomy. Another entirely different view of the omentum is obtained from the study of general anatomy. From time immemorial, and practically without any alteration in detail, anatomists have contented themselves with a description of the omentum as being "a complicated folding of the peritoneal surfaces," submitting careful descriptions of the several layers with their origin. The omentum is a reticulation of connective-tissue, carrying a double fold of peritoneal membrane, extending from its parietal attachment on the posterior abdominal wall, down more or less deeply into the abdomen, then up to become attached to the lower portion of the stomach and gastro-splenic ligament. The retrogastric space,

*Read at the 140th annual meeting of the Medical Society of New Jersey, June 1906.

which includes the space between the folded peritoneum not obliterated by adhesions of its surfaces, is known as the cavity of the greater omentum. Its connection with the general cavity is at the right of the stomach in the foramen of Winslow. This cavity varies in size; in childhood extending down into the fold of the omentum; or, owing to adhesive obliteration of the lower sac in adults, or absorption, this cavity often does not extend much below the lower margin of the stomach^{2 6 17}.

The omentum possesses a remarkable vascular supply; its arteries coming from the gastro-epiploic, right and left; its veins empty into the portal vein. No nerves have been demonstrated, nevertheless, vasculomotor and trophic nerves must exist to innervate the different structures contained. The lymph stream is abundant and empties into the glands on the greater curvature of the stomach—in some cases fifteen or more may be seen. The majority are found between the greater curvature and the transverse colon, although some may extend below the lower border of the colon^{9 16}. The lymph stream, after it passes the first chain of glands, empties into the retro-duodenal and from there into the receptaculum chyli¹⁴. According to A. S. Warthin, haemolymph glands of the splenic type are found—their position not being stated. Melissinos, however, says that they are more numerous between the spleen and greater curvature of the stomach.

According to Robinson, many times in a hundred autopsies the omentum is entirely out of sight—rolled up above or under the transverse colon. In ten per cent. of the cases it may cover the caecum, and in twenty per cent. reach into the pelvis. It tends chiefly to the left and is found in three per cent. of all the hernia^{18a}. The position of the omentum in the abdomen is determined in part by the pumping action of respiration, intra-abdominal pressure, or more largely by the peristaltic movements of the intestines. By means of the latter the omentum is kept unfolded and is drawn to different parts of the abdomen with the movements of the intestines, so that each portion of the peritoneal cavity is touched at times by this membrane. The descensus of the same into the abdomen will depend not only on its length, but upon the position of the lower border of the stomach.

Histology. The ground substance of the omentum is composed of connective-tissue made up of a variable amount of fibres, white and elastic. The white fibres are ar-

ranged in a reticular manner, connecting with each other. The meshes of the reticulation are occupied by the ground substance of the membrane, bridged over by the flattened cells of the surfaces. These meshes may become open in many parts owing to absorption of the intervening ground substance and the perforation of the cells covering it¹⁷. Klein says that in those animals in which the omentum is fenestrated in the adult condition it is not, or only imperfectly so, in the young condition, being then a continuous membrane composed of a layer of connective-tissue bundles. This fenestration is produced by cavities appearing between the connective-tissue bundles, which cavities open through the interstitial cement substance of the surface endothelium. A direct transition of connective-tissue corpuscles into endothelial cells of the surface is hereby established. Lying upon these bundles of fibrous tissue are connective-tissue nuclei or corpuscles. The corpuscles here and elsewhere belong to the fibrous tissue, and when separated from them the bundles suffer in nutrition and are extremely liable to die. Along with the bundles of fibres are intimately bound up arteries and veins; lymphatic vessels and lymph-canalicular spaces. The lymphatic vessels are composed of a thin endothelial wall; the lymph-canalicular spaces contain an albuminous fluid. The number of these lymph vessels varies in different parts⁴. The omentum is especially rich in groups of germinating cells; in many instances they are found on the surface of special thickenings of the normal membrane in connection with the vascular system. Sometimes they are found on peculiar papillary projections, particularly under pathological relations. The germinating endothelium sometimes contains cells which are in the act of division. Some are free and possess the power of amoeboid movement, approaching the nature of the lymph-corpuscles. After becoming free, they find their way into the lymphatic vessels and then into the blood vessels as colorless blood-corpuscles. In many mammals the amount of such germinating endothelium is very great, hence this membrane plays an important part in the generation of lymph and colorless blood-corpuscles.

The omentum also contains nodular or cord-like groups of adenoid tissue covered on one or more surfaces with germinating endothelium. These masses have either well-defined outlines or are more or less diffuse. According to Klein, the lymphatic

tissue in the omentum, being possessed of a special system of blood vessels, may at one time functionate as connective-tissue, or at another time as fat-cell tissue⁵. There is a large amount of adipose tissue which, towards the end of life, particularly in those people tending to obesity, accumulates considerable fat. The surface of the omentum consists of a layer of endothelial plates (120 m.m. in thickness) which are elastic; their interstitial cement substance being very soft. According to the state of contraction or expansion of the subjacent membrane or the direction to which it is being drawn, so will the shape of these plates be altered. There is a direct transition of connective-tissue corpuscles into endothelial plates of the surface⁸. Von Recklinghausen's claim, that on the surface of the peritoneal cavity were stomata through which fluids freely passed to the lymphatic channels, was so plausible in consideration of the rapid absorption of fluids from the peritoneal cavity, that it went undisputed by histologists for considerable time, until Muscatello and others disputed the presence of them¹¹. MacCallum, in a strong paper, controverts the statement that openings exist, and negatives the idea that the peritoneal cavity is a part of the lymphatic system, and even further disputes that the endothelium has any connection with the adjacent connective-tissue cells, claiming an independent development¹¹. Sabin claims, according to embryological investigations, distinctive origins for the endothelial cells and the subjacent lymphatics.

Functions. The several functions of this membrane are determined by the different tissues which go to make up its substance, and as this organ is insuperably connected with other tissues contiguous, much that pertains to the functioning of the omentum is associated with similar conditions existing in nearby structures. The study of one implies a knowledge of the action of all. From the time of the early anatomists the sole function attributed to the omentum was that of protector of the intestines against chill. Like many fictions in medical literature this has long gone without protest. Of how little value it may be to the underlying intestines can be appreciated by any one who has taken the trouble to introduce a thermometer into a deep sinus and watched for the effect of an ice-bag on its reading.

I—Circulation. The large blood supply of the omentum makes it an important factor in maintaining an equilibrium of blood circulation. Physiologists teach the import-

ance of the correlation between the intra-peritoneal circulation and external conditions. Necessity demands, for relief of arterial tension, that some part of the circulation be capable of storing up blood. This the intra-abdominal vessels are alone capable of doing with safety, being aided by the sensitiveness of the splanchnics to reflex irritation. Surgeons frequently note that during operations long prolonged the omentum changes color and becomes turgid with blood²³. Crile holds that shock is due to reflex vaso-dilatation of the splanchnic area. The omentum with its loose tissues and numerous vessels must play an important part in this phenomenon. Under conditions which increase the pressure of blood in the portal system the veins of the omentum become distended, and from them passes into the peritoneal cavity ascitic fluid. One observer, after amputation of the omentum for some incidental condition, noted¹ the disappearance of the ascitic condition co-existing. The omentum in its excursions through the abdomen may become adherent to some area of local inflammation and a collateral circulation sufficient to relieve the venous tension is established.

II—Absorption. Another important function is attained through the vascular system of the omentum in conjunction with the lymphatics; that is, the absorption of fluids and the taking up from the peritoneal cavity of suspended solids²². Wagner estimates a dog's peritoneum as capable of absorbing in one hour an amount of fluid equal to $\frac{3}{8}$ per cent. of the animal's body weight²². Du Bar and Remy found the thoracic duct of a rabbit greatly distended in five minutes after a large intra-peritoneal injection of albuminous fluid—the greater the percentage of albumen, the less rapid the absorption. Absorption in the peritoneal cavity is partly by the lymph stream and partly by the blood stream. This absorption is not only of fluids, but of insolubles. Muscatello and Salzel claim that the solid particles are carried by the wandering cells to the lymph stream, and the fluids largely by the blood. Various factors influence the rapidity with which fluids are absorbed in the peritoneal cavity and the amount absorbed. Only under normal physiologic conditions can the maximum be obtained. The rapidity is regulated by two factors; the pressure exerted by the abdominal muscles and the movements of the diaphragm and intestines—the diaphragm acting like a pressure and suction pump. The movements of the intestines prevent the accumu-

lation of fluid in any one part, so that it cannot follow the law of gravitation. They carry the fluids over the absorbing surfaces of the peritoneum and in this way greatly enhance the absorbing powers.

According to Nothnagel¹⁴, the absorption of intra-peritoneal fluid is directly proportionate to the activity of intestinal peristalsis. Reduction in temperature of the peritoneal cavity reduces the absorptive power of the omentum, due to diminished peristalsis; dilatation of the blood vessels and increased peristalsis tending to promote absorption. Dudgeon and Sargent in their book on "The Bacteriology of Peritonitis"²² claim that whatever absorption cannot take place by the lymphatic channel must be done by means of the blood stream. Provided that the endothelium is uninjured, bacteria and other foreign substances will be safely disposed of by the lymphatic route; but damage to the endothelium will at once allow absorption to take place by the vascular route, the extreme delicacy of the peritoneal membrane rendering it particularly susceptible to injury. The factors which retard or stop absorption have been investigated by Wagner and others, and are generally pathological. Venous engorgement may increase the peritoneal content. Reduction in the energy of intestinal peristalsis, together with diminished activity of the diaphragm and loss of tension of the peritoneal muscles retard absorption.

According to Byron Robinson¹⁸, the organ that the cells of the peritoneal cavity seek to become attached to is the omentum. Oppel has suggested that the path taken by the lymph stream from the peritoneal cavity is chiefly by the great omentum. He gives as his reason that in many cases where the peritoneal lymph was free from bacteria a deposit of micro-organisms was found on the great omentum. Lodi¹⁴ states that the omentum plays an extremely important part in the absorption of both micro-organisms and solid particles in the peritoneal cavity. Durham found that in an animal killed twenty minutes after an intra-peritoneal injection of bacteria, the omentum contained bacteria, while the peritoneal cavity was sterile on culture. Muscatello observed color particles taken up by the phagocytes, which rapidly passed between or through the endothelial cells into the subjacent lymph spaces. The nerve supply of the omentum, according to Marcy¹², plays an important role in the organism, maintaining a suitable equilibrium of flows in the abdominal cavity.

III—Cohesive and Adhesive Properties. The cohesive tendency of the omentum is first evidenced in foetal life, when the mesogastrium unites with the mesocolon through either degeneration and absorption of the endothelium, or more likely a retrograde metamorphosis of endothelia into connective-tissue corpuscles. This same tendency can be demonstrated in advanced life when conditions are suitable, and is often noted when the omentum becomes incarcerated in a hernia. The adhesive tendency of the omentum is a property peculiar to itself, as is the cohesive. When this membrane is irritated either through some regional inflammation or point of disturbed circulation, there is a transudation onto its surface, as well as into its superficial structure, of an exudate composed of white-blood cells and fibrin, which produce a stickiness. This leads the omentum to become attached to the offending portion and to encapsulate it. Continued irritation will lead to a marked hyperplasia of the omentum. If the source of irritation does not contain germs too pathogenic or too numerous, or if the phagocytes and the opsonic condition be satisfactory, the ultimate result will be a restitution and gradual absorption of the hyperplased and exuded material and a return to normal. Not all of the endothelia being disturbed, new endothelia are formed. In the sub-endothelial tissue is maintained an excess of the fibroid which will materially interfere with subsequent absorption from that point. If the disturbance to the peritoneum be more or less general, there is, as we find clinically, an acquired immunity to secondary infections. Experiments by Schlitzler and Ewald show drying of the peritoneal surfaces to be an important element in the genesis of peritoneal adhesions; at the same time it retards the rate of subsequent absorption of fluids.

IV—Protective Role. The wonderful discovery by Metschnikoff of the phagocytic action of the white-blood cells receives no better illustration of its value in the economy than in the peritoneal cavity, as this is greatly prone to invasion. The slight amount of tissue separating the contents of the intestinal tract from the sensitive peritoneum, and the numerous organs subject to lesion and traumatism, render this cavity particularly susceptible to microbic invasion. Had Nature not a method of protection sufficient for ordinary disturbances, life would not be long lasting. In phagocytosis we have this means of protection and in the omentum a ready organ for its elaboration

and action. The phagocytes, drawn from the periphery by chemotaxis, associated with those formed from the transformed endothelia, the adenoid and connective-tissue of the omentum, are extruded into the peritoneal cavity. The peritoneal cavity normally contains a small amount of clear fluid in which are suspended a number of cells. The character of these cells, according to Kanthak and Hardy is 30 per cent. to 50 per cent. polymorphonuclear.

Opie²⁴ states that polynuclear leukocytes with fine granulations accumulate in great quantity on the surface of the omentum and form compact clumps held together by a network of fibrin. The eosinophile leukocytes in large number penetrate into these masses of cells. He further claims that the eosinophile cells rarely if ever ingest bacteria. Dudgeon and Sargent's experiments²² seem to demonstrate that the granular eosinophile cell, which some have considered to be non-phagocytic and others slightly so, to be one of the most important, if not the most important, phagocyte in the early stages of peritoneal infection, while the finely granular polynuclear cells become a well-known important phagocyte in the later periods of peritonitis. These same writers claim that on irritation of the peritoneal cavity, the staphylococcus albus appears on its surface, before there is any solution of continuity. It is generally found at a distance from the focus of irritation in association with numbers of phagocytes. Their conclusion is that from some unknown source this germ enters the peritoneal cavity ahead of all other more pathogenic germs, spreads rapidly over the entire peritoneum and omentum, and, by its minor irritation induces a rapid transudation of phagocytes, thus preparing the cavity to attack more virulent germs when they appear. Thus the omentum as a surgical factor in laparotomy is comprehended. There is a general definite relation between the lymph flow and cell-intrusion in the peritoneal spaces; the obliteration of the lymph channels from the peritoneal membrane by constriction of cicatricial tissue explaining why repeated lymphangitis becomes less and less dangerous.

Rogers¹⁹ considers the great omentum a flattened ganglia. To demonstrate the protective role of this membrane, he extirpated the omentum in rabbits and guinea pigs. Later, after a period of a month or two, he injected into the abdominal cavity of the animals thus operated upon a few drops of the virulent culture of staphylococcus aureus. Death supervened in twen-

ty-four hours, or at the latest within two or three days. Controls of the same weight to make the conditions identical having been subjected to a simple laparotomy, received the same amount of culture, but survived. It should not be concluded, however, that the extirpation of the omentum entirely destroys the resistance of the peritoneum, for the animals thus operated upon survive if they receive a very small dose of a virulent culture, or if an attenuated microbe be employed. In repeating the inoculation, however, he noticed that the animals deprived of the omentum grew thin and cachectic, and finally succumbed, while the control animal manifested no disturbance whatever. This role of the omentum is especially marked in the young, because with age a fatty infiltration occurs which diminishes the activity. It is, however, in children that the peritoneum is frequently threatened by microbes which swarm in the gastro-intestinal canal and so often cause inflammation there. The plastic exudate thrown out by the omentum at the point of lesion doubtless offers some purely mechanical protection against the spread of infection; it may also be that the secretion poured out from the omental vessels has some antitoxic action. Further, the bacteria received into the lymphatics of the omentum are either rendered less virulent, or are else destroyed.

Byrom Robinson says¹⁸, "the great omentum is a valuable peritoneal veil. It may present many cicatrices showing old peritonitis. It prevents the invasion of infection, and circumscribes inflammation. It is a great peritoneal protector, and the surgeon's friend, burying the mischief he has wrought. It may show by old inflammation that it has checked peritonitis." Experiments by Schlitzler and Ewald¹⁴ show a property of the omentum to be the rapid formation of plastic tissue on irritation, when an engorgement of the vessels takes place. Robinson¹⁸ claims that in nearly all experiments when peritonitis or congestion arose the most intense congestion appeared in the omentum, and thus in peritonitis in both man and animal this intense congestion of the omentum is a characteristic feature. He claims that the omentum in peritonitis attempts to corral the phagocytes, or their adherent microbes, by taking them out of the peritoneal fluid and making them adhere to its sticky surface. Careful examination will show that it harbors microbes while the peritoneal fluid is sterile, but, if the microbes be very virulent, the stickiness of the surface will not suffice to

ensnare or destroy them. According to Warthin²¹, after removal of the omentum, animals are more susceptible to intra-peritoneal injections of micro-organisms. In local traumatism, after operations and in local peritonitis, the omentum is commonly found attached to the affected area, shutting it off. The slightest irritation is sufficient to cause the omentum to attach itself.

V—Supplemental Function. De Renzi¹ found that if the circulation of the spleen be entirely cut off the omentum gradually envelopes and forms a capsule around it, inside of which it is in time completely absorbed. If the omentum be removed after the circulation of the spleen be cut off, the organ does not become encapsulated, and the animal speedily dies. When toxins are generated by gangrenous degeneration of the spleen or other organs, the omentum seems to possess the power of neutralizing these toxins. Pirrone¹⁵ confirms the findings of De Renzi, and claims that the action is done by phagocytes originating in the omentum and devouring the detritus of the spleen. He compares the endothelium of the omentum to that of the blood vessels in respect to thrombus. He claims that after extirpation of the spleen, there is nothing to indicate that the omentum undergoes modified transformation to compensate for the missing organ. Pirrone proved the phagocytic action of the omentum. He experimented with injections of sodium taurocholate in splenectomized animals and induced immunization from this drug. When he compared the results with those obtained with non-splenectomized animals, he found that the omentum had evidently tried to compensate for the absent spleen. Compensatory plastic processes in the lymphatic follicles were unmistakably apparent. The findings suggest functional relations between the spleen and the omentum beyond what physiologists have hitherto imagined. Warthin²¹ finds haemolymph glands of the splenic type existing in the omentum, and it is possible that they may take on vicarious action, become enlarged, and functionate for the destroyed spleen.

Resumé. 1.—The numerous blood vessels and lax tissues of the omentum allow of storage of blood when the general arterial tension is high.

2.—By venous anastomosis through adhesions local congestion may be relieved.

3.—Through its large surface, freely exposed to surrounding parts in motion, it becomes a rapid absorber of fluids by the blood stream.

4.—By the lymph stream it is a free carrier of white-blood corpuscles, encapsulating solid particles.

5.—Through its cohesive tendency, apertures in the abdomen into which the omentum has been forced by intra-abdominal pressure become more or less completely closed.

6.—Through its readiness to lymph formation and local proliferation, it becomes attached to infected parts, which are walled off, subsequently to be absorbed by phagocytic action; the peritoneal cavity thereby protected.

7.—The majority of the phagocytes extruded into the peritoneum for its protection come through the omentum, largely from the general circulation, but in part from the tissues therein existing; subsequently to be attached to the surface of this tissue, taken into the lymph stream, and subjected to the cytolytic influences existing there.

8.—Lack of development of the omentum, or loss through operation, renders one less resistant to peritoneal invasion.

9.—Haemolymph glands of the splenic type existing in its base supplement the spleen if the latter be removed or its functions interfered with.

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SYMPOSIUM ON APPENDICITIS

FIRST PAPER

THE ETIOLOGY OF APPENDICITIS*

By T. H. Mackenzie, M. D., Trenton, N. J.

To understand the cause of appendicitis it will be necessary to study the anatomical, physiological and histological peculiarities of the appendix. A knowledge of these is essential to enable us to arrive at the morbid agents which enter into the complex pathogenesis of this disease.

The appendix arises from the posterior surface of the caecum, in the greater number of cases, about an inch below and to the right of the ileo-caecal valve. It may vary in length from one centimeter to twenty-three centimeters. The appendix is completely covered by peritoneum at its distal portion, but throughout the proximal half or two-thirds, there is usually a meso-appendix. The meso-appendix is sometimes absent and the appendix hangs free in the peritoneal cavity. And again the appendix may be entirely subserous, and in such a case runs up behind the caecum and may lie to the right or left of that organ. The meso-appendix is a double layer of peritoneum, and is usually triangular in outline; its free border forming the base, the apex is at the root of the appendix, the mesentery and the appendix forming the other two sides of the triangle.

The appendix is supplied with blood by the ileo-caecal artery, which passes with the veins and nerves between the layers of the meso-appendix. At the mouth of the appendix there is a prominence of mucous membrane, caused by an increase of lymphoid tissue, forming a small valve, known as Gerlach's valve, which favors occlusion of the orifice. The meso-appendix may be regarded as a factor in causing appendicitis because of the fact that its breadth is not always commensurate with its length; for, if the meso-appendix be relatively narrow as compared with its length, the appendix will be correspondingly curved or distorted. The curvative flexion, or distortion, thus caused will interfere with drainage, which is so essential to its healthful condition. Excessive length of the appendix as compared with its width also impairs its powers of draining itself of its contents, thus becoming an etiolo-

gical factor. The relation of the diameter of the lumen to the length of the appendix is as one to sixteen or twenty-five. The disproportion is evidently of etiological significance.

Physiologically, the appendix is regarded as a lymphoid structure, so much so, that it is often termed the abdominal tonsil, and its coats are similar to those of the caecum. This is significant from the fact that lymphoid tissue, here as elsewhere in the body, is prone to inflammation and suppuration. The lymphoid elements are more abundant in childhood than in old age, hence we find a greater number of cases of appendicitis in adolescence and early adult life. Although the function of the appendix is not so well understood, yet the general consensus of opinion among surgeons is that both the caecum and appendix perform a specific function, and the observations of McEwen seem to verify this opinion. McEwen concludes, after careful study of this subject, that the caecum and appendix are of value in digestion. The significance of this is that, when its function is impaired, from any cause whatever, the pathological condition attending such impaired function may act as a predisposing cause of appendicitis.

Among the clinical factors that enter into the causation of appendicitis may be mentioned age, sex, heredity, previous attacks of appendicitis, and certain other diseases. The reason for the relative exemption of the disease in advanced life is found in the atrophy or retrogression of the adenoid tissue of the appendix in the aged, as well as their more judicious mode of life.

Statistics would seem to indicate that appendicitis occurs about as frequently in the female as in the male. Appendicitis in the female is coincident with, or a consequence of adnexal disease in about thirty per cent. of such cases. Heredity also seems to have an influence in appendicitis. We frequently find several members of the same family affected by the disease.

Among the predisposing causes of appendicitis may be mentioned such other diseases as constipation, gastro-enteritis, dysentery, typhoid fever and influenza. Constipation probably acts by making the coli communi, the natural habitat of this region, more virulent. Gastro-enteritis acts as a cause of this affection by the spreading of the catarrh of the intestinal mucous membrane to the appendix and also exciting the coli communi to greater virulence. Dysentery, as a causative agent, probably acts in a similar way to that of gastro-enteritis. Typhoid fever is

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not only a direct, but a remote, cause of this affection. It has been proven that ulceration occurs in the appendix and runs a course similar to ulceration in other parts of the intestinal tract. That is, the ulceration of the appendix may become perforated or may heal and cicatrize and in this way lessen the caliber of the lumen of the organ and thus act as a predisposing cause of a future attack of appendicitis. Influenza is also considered an exciting cause and may occur by the influenza bacillus finding its way into the appendix and thus directly exciting appendicitis. An important predisposing cause is a previous attack of the same affection. For it is a well-known fact that one attack of appendicitis predisposes to another. Dr. Deaver reports that a history of a previous attack could be obtained in eighty-five per cent. of his cases.

Disturbances of digestion is one of the most frequent exciting causes of appendicitis. The disturbance of the intestinal tract attending indigestion may spread to the appendix, causing swelling of the mucous membrane, preventing drainage and thus causing inflammation. That exposure to cold and other deleterious influences act as exciting causes, there can be no doubt. The foregoing conditions sometimes act as predisposing factors, and at others as exciting causes of the disease. The essential exciting cause, however, of the dread affection is beyond doubt bacterial infection of the appendix. The other factors, as above mentioned, as well as such others, as trauma, parasitical invasion of the appendix, interference of the blood supply by adhesion, and angulation, are contributory as predisposing causes. Bacteria are the active agents in causing the inflammatory process leading up to the disease. The coli commune always present in the appendix, rendered virulent by impaired drainage, is more frequently the offending agent. It is conceded, however, that the streptococci, staphylococci, pneumococci, and other pyogenic organizations are also active agents in the production of this affection.

To recapitulate, among the factors that operate to render the appendix less resistant to bacterial invasion, and the other determining causes of appendicitis, may be mentioned defective blood supply, arising from angulation, contortion and bands of adhesion. Impaired circulation and nutrition are also produced by ineffectual peristaltic efforts on the part of the appendix to rid itself of offending foreign bodies, such as calculi or inspissated foecal matter. An-

other significant factor rendering the appendix less resistant to bacterial invasion is atrophy or retrogression of the organ. In short, any cause whatever that acts as an interference with thorough drainage of the appendix acts as a predisposing cause; inasmuch as it will increase the virulence of the bacteria normally present in the intestine. Defective drainage may result when, from any reason, the appendix is unable to expel its contents, its lumen may be restricted by bands of adhesion, cicatrices, calculi or other foreign bodies that may be lodged in the appendix. Catharrhal condition of the caecum may spread to the appendix, causing swelling and obliteration of its outlet, thus hindering thorough drainage.

In connection with the subject of drainage, the anatomical and physiological peculiarities of the appendix play an important part; of these may be mentioned the size and shape of the meso-appendix; the excessive length of the appendix as compared with the caliber of its lumen; the lymphoid tissue of the mucous membrane subject to inflammatory process—thus reducing the caliber of the lumen of the appendix and hindering thorough drainage. Appendicular calculi have a two-fold action: they not only occlude the lumen of the appendix and thus prevent drainage, but cause erosion of the mucous membrane and thus lessen the resisting power of the organ to bacterial infection.

At the risk of repetition, let me say again the bacterium coli commune, which at one time was looked upon as a harmless inhabitant of the intestine, has now been proven to be an organism possessing pathogenic properties. As an evidence of this I will cite the experimental production of peritonitis by the introduction of cultures of this organism. It has been satisfactorily proven in recent years that under a variety of circumstances they become greatly increased in virulence and their toxins acquire poisonous properties to a high degree. This acquired virulence occurs in a number of diseased states, such as obstruction, strangulation, congestion, typhoid fever, etc.

From the foregoing, therefore, we can easily understand that the conditions in the appendix are most favorable for the sudden and rapid increase in the virulence of a bacterium that was formerly innocuous in other portions of the alimentary canal. The appendix, like the intestine, under normal circumstances contains a variety of bacteria; but under conditions favorable for the development of appendicitis, particularly when

the lumen of the appendix becomes occluded, the bacterium coli commune rapidly becomes the predominating and most virulent organism.

SECOND PAPER.

THE DIAGNOSIS OF APPENDICITIS*

By E. W. Hedges, M. D., Plainfield, N. J.

Just twenty years ago appendicitis was first definitely diagnosed. It was in 1886 that Reginald Fitz, of Boston, disentangled inflammation of the appendix from the mass of conditions with which it had been confounded, and made clear the distinction between it and typhlitis, peri-typhlitis, inflammation of the bowels, peritonitis and other lesions. Melier in 1827 recognized that distinct symptoms arose from lesions of the appendix, and various writers after him referred to the same fact; but Reginald Fitz made the condition stand out as a separate thing, apart from all else, and to this Boston physician belongs the full credit for launching the vermiform appendix upon a career of its own. When he, with considerable hesitation, coined the word "appendicitis," he little imagined that around the word and what it stands for, would rage the fiercest surgical debates the world has ever known. The golden apple among the goddesses never stirred up more strife than does the mention of this word at almost any medical gathering. I have seen a thousand delegates in the Surgical Section of the American Medical Association wait for an hour after the time for dinner had arrived while Deaver and Ochsner, Price and Murphy, Keen and McCosh fought out amid wild applause the question of when to operate. We do not look for such pyrotechnic displays when the diagnosis is under discussion, and yet after all a correct diagnosis is more important than any other phase of the subject.

From the fact that this disease when recognized at its beginning can be safely dealt with, but that when undetected till an abscess has formed, it becomes one of our most dangerous surgical conditions, the need of an accurate diagnosis is clearly seen. The large number of pus cases that come to the surgeon after the attack has lasted three or four days bear undeniable testimony to the fact that the initial symptoms of the disease are not always recognized, and yet, with a little care and attention, we believe the pres-

ence or absence of appendicitis may in almost every instance be clearly demonstrated. The three so-called cardinal symptoms of pain in the right iliac fossa, tenderness on pressure over the McBurney's point and rigidity of the right rectus muscle are important, but I do not believe a positive diagnosis can be built up on the presence of these signs alone.

Sudden pain is the first symptom to appear and the most important, and this pain at first is apt to be diffused and general over the abdomen because the superior mesenteric plexus of the sympathetic which supplies the appendix, also largely supplies the intestines, and because irritative nerve pain is apt to be referred to the peripheral extremities of nerves; soon after it is felt about the umbilicus, because as such pain increases in intensity it is often referred to the nearest nerve center, and the great sympathetic ganglia of the abdomen are situated in that region. After from eight to twelve hours, however, this pain is likely to settle in the region of the appendix. But when we remember that the appendix may vary in length from a quarter of an inch to ten inches, and that it may point in any direction, we can readily understand how the pain may be from near the region of the liver above, to the ovary below, or even to the left of the median line. Indeed left-sided appendicitis may occur not only from a long appendix, but from a transposition of viscera or a moveable cæcum. When the appendix is behind the cæcum the pain may be in the lumbar region. It may be in the bladder with distress and frequency of urination if the appendix is long and adherent to that organ.

This pain may be only a discomfort, or it may be very severe. In an acute infective case it reaches its greatest intensity in about four hours. A sudden subsidence of the pain indicates a discharge of the appendiceal contents into the cæcum, rupture of the wall of the appendix, or the development of gangrene. The pain is always increased by pressure, thus diagnosing appendicitis from colic, which is relieved by the same pressure. It is also increased by motion of any kind. The patient will often lie with the right knee raised, flexing the thigh or the abdomen so as to diminish the pressure and consequent discomfort. Careful inspection of the belly wall often shows it to be motionless below the umbilicus, the breathing being largely thoracic and the respirations somewhat quickened because of their shallower character, ranging from 22 to 24. Within three or four hours after the pain has begun in the acute infective cases we may look for

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nausea and vomiting. Then symptoms are reflex and due to the pressure of the accumulated products of infection within the appendix; after one or two efforts at emesis the primary nausea usually passes away. Secondary nausea and persistent vomiting are due to periappendicular involvement. In mild catarrhal cases nausea is often entirely lacking. The vomiting is a pretty fair index of the severity of a case, being absent in mild cases and pronounced in those that are severe. Tenderness on the right side—particularly over the appendix—is always present, though not invariably at the beginning of the pain. After a few hours—twelve at the outside—this symptom can be elicited. Should the appendix lie in front of the cæcum this tenderness is greatly increased by pressure: if behind, pressure does not greatly aggravate it. The right rectus is found rigid, protecting the inflamed organ, as only Nature knows how to do, from rude handling. As for palpating the appendix to aid in diagnosis, if the appendix is swollen enough to be felt it is dangerous to attempt to palpate it, and if not swollen enough to be felt, then such a procedure is useless.

The temperature rises in every acute infective case within a few hours, generally within three or four. In milder cases it may be twenty-four or even thirty-six. A high temperature coming on rapidly would indicate a severe type of infection; while on the contrary a small amount of fever coming on sixteen to twenty-four hours after the pain would indicate a milder attack. The temperature may entirely subside after the first twenty-four hours. Sudden subsidence may mean gangrene of the mucosa, which prevents further absorption and therefore causes a drop in the temperature. Gradual subsidence indicates a cessation of pressure, either because of rupture into the meso-appendix or the formation of circumscribing adhesions about the appendix. The temperature may go down after the initial rise and yet there may be a large pocket of pus present. A secondary rise of temperature means a fresh invasion of tissues and is an indication for operation. Some writers warn against placing reliance upon mouth temperatures, claiming that when the skin is cold and clammy there is a great determination of blood to the peritoneal cavity, with a much higher rectal temperature than can be found in the mouth. In fact, it is claimed that when the rectal temperature is over a degree and a half higher than the mouth temperature, a diagnosis of appendicitis may be made from that fact alone. Every case

of acute infective appendicitis has fever just as certainly as it has pain. Murphy of Chicago says he would not operate on a case where he was confident there had been no rise of temperature in the first thirty-six hours.

Sometimes we find bulging on the right side from accumulated flatus or from an abscess. Later on, if peritonitis develops, the abdomen becomes barrel shaped. If rigidity is not too great we may be able to make out a tumor over the appendix. The pulse rises rapidly and bears a close relation to the amount of inflammation present. A full rapid pulse shows advancing peritonitis. Perforation gives a rapid feeble pulse. In spite of the fact that you may sometimes find a normal pulse in grave intra-abdominal conditions in the most of cases, such as those with perforative peritonitis, it remains true that the pulse gives a very fair idea of the gravity of the disease. A rapid increase of pulse out of proportion to the fever means gangrene, perforation with infection or general septicæmia. An undue importance has been given to the leucocyte count as an aid to diagnosis. A leucocytosis to 15,000 or 18,000 will generally be found if pus is present, but not invariably. If successive tests be made and the leucocyte count is rising, that with other symptoms makes a fair presumption of appendicitis. Constipation is generally present; if we find diarrhoea it is a good sign as evidencing that there is no paralysis of the bowels.

The attitude of the patient is generally quiet, on the back with the right thigh flexed. The expression is distinctly anxious and this is an important fact to note. The dominant symptoms of acute infective appendicitis are sudden and severe pain, nausea and vomiting sometimes within the first four hours, tenderness, at first general, and then becoming focussed at McBurney's point, and fever coming on within a few hours to a day after the beginning of the pain; and these symptoms must come in the order named. Pain is always present and is always the first symptom. If the history shows that fever preceded any other symptom we can rule out appendicitis—possibly typhoid is coming. If nausea and vomiting are the first symptoms, we may suspect gastritis. Where the attack is merely catarrhal some of these symptoms may be lacking; nausea does not always come in mild cases. Fever may be practically absent, but even here we will find pain increased by motion, tenderness on

pressure and rigidity of muscles. In every case of sudden, sharp, abdominal pain we must suspect appendicitis and not let go our suspicions until the appendix has proved itself innocent. The law supposes every man innocent until proved guilty, but if we adopt this generous policy toward the appendix, many a vicious vermiform that sadly needs a noose about its neck will escape.

There are a number of conditions with which we may confound appendicitis. In pneumonia and diaphragmatic pleurisy we may have pain over McBurney's point, tenderness there on pressure and fever; yet the pain is not the first symptom complained of. Moreover the tenderness is more superficial, deep pressure being better borne than light. This is due to the fact that the lower intercostal nerves which send branches to the costal pleura have other branches running down the abdominal wall as far as the anterior superior spine of the ileum and irritation of pleural fibres may give pain felt in the region over the appendix. Of course a careful examination of the lung would show the evidences of local disease there and this examination should always be made. Hepatic colic is a harder condition to differentiate. Here we have the sudden pain, with nausea, vomiting, rigidity, prostration and anxious look, just the same as in appendicitis; but the pain and tenderness are higher up close under the ribs. In hepatic colic the pain radiates toward the shoulder; it never does that in appendicitis. In hepatic colic the vomiting continues longer and is more intractable, and we may have some jaundice with putty colored stools and dark urine. Yet at the beginning they may be as much alike as two Dromios and almost every surgeon of large experience has opened the abdomen for the one condition and found the other.

Nephritic colic, too, is something we must be always ready to rule out. In this the pain radiates toward the groin and into the testicles and sometimes to the rectum, giving rise to tenesmus and a desire to go to stool. The sensitiveness is greatest posteriorly over the pelvis of the kidney, vomiting is not frequent, the bladder is irritable. There is dysuria and vesical tenesmus and occasional hæmaturia. The testicles are retracted. If we see a case when the renal stone has begun to pass out through the ureter the diagnosis presents some further difficulties, but the more intense character of the pain, coupled with the urinary symptoms, ought to make the distinction clear. Right floating kidney with twisted pedicle may give

symptoms similar to those of appendicitis, Anuria is apt to be present, and if we can get a history of a movable tumor in that region, we should strongly suspect the kidney. I shall never forget the time when I removed an atrophied right kidney embedded in a mass of adhesions just where the appendix should be, in a case presenting a perfect picture of acute infective appendicitis in every detail. The history pointed to an adhesive inflammation several years previously that had fastened it just above the brim of the pelvis.

Intestinal obstruction has vomiting, at first the contents of the stomach, then bile, and later feces. There is obstipation and early collapse. There is no fever at the beginning, no leucocytosis and an absence of early abdominal tenderness. Obstruction may complicate the case, owing to the bands of inflammatory lymph thrown out from the appendix. This gives more vomiting, constipation and inability to pass flatus. Peritonitis, from delayed or suddenly arrested menstruation, which produces a congestion of the whole pelvis, has sometimes so closely simulated appendicitis as to cause operation, but the swollen abdomen lacks the tenderness that it has in appendicitis. Gastritis may have all the symptoms of appendicitis save those referable to the right iliac fossa and the absence of these should differentiate. Acute enteritis in children will give pain, vomiting, tenderness and fever, but the frequent offensive stools should point to the real difficulty. When the enteritis is accompanied with an exudate it is hard to tell, save by this sign.

Foreign bodies or even fecal concretions in the cæcum sometimes give every symptom of the disease we are discussing and deceive even the elect. Nothing but an exploratory laparotomy will give the certain diagnosis. The perforation of a gastric or intestinal ulcer makes a hard diagnosis at times; but the history of previous bleeding and the fact that the location of pain and tenderness is not apt to be over the appendix should help us to decide against appendicitis. A laparotomy may show even the most careful diagnostician that he has erred. Typhoid fever presents a nuzling condition if you are called in the middle of an attack and can get no history; but where the history is present, the absence of pain and tenderness at the beginning should help us to differentiate. Intussusception gives bloody and mucus stools, a more movable tumor which is sometimes relieved by pressure. Lead colic may have vomiting, pain and col-

lapse, but the absence of general or local tenderness, the slow pulse and increased arterial tension, with no rigidity, separate it definitely from appendicitis.

Tubercular peritonitis has more moderate fever, less abdominal tenderness, felt most when suddenly letting up on pressure, and an indefinite localization. This also has more frequent fecal vomiting. Hysterical attacks of pain in the right iliac fossa are often mistaken for appendicitis; but the absence of fever, no leucocytosis, the disappearance of pain and tenderness when the attention is diverted and the absence of the anxious expression, ought to put us sufficiently on guard to keep us from error in diagnosis. Yet I have in good faith removed several hysterical appendices and if my life is spared, I presume I will remove some more. Salpingitis and pyo-salpinx have the pain and tenderness lower down and a vaginal examination should set all doubts at rest. Some irritation around the stump of an ovary that may have been removed years before may seem like an inflamed appendix; so might a dozen other things. It is not always easy to tell an appendicitis, though in the majority of cases a careful review of the symptoms will keep us from error.

We might with profit learn modesty in diagnosis from one of our best surgeons who, when about to operate, often says: "This is a case of appendicitis; that is, I think it is."

THIRD PAPER.

COMPLICATIONS AND SEQUELAE OF APPENDICITIS.*

By Paul M. Mecray, M. D., Camden, N. J.

The part assigned to me in this discussion is the complications and sequelæ of appendicitis, or what might be termed accidents incident to appendicitis. When we come to separate these complications from the disease itself, we meet with difficulty, as many of them are practically a part of it. What appears to me to be the best way to discuss such a broad array of conditions, is to divide the subject into two main divisions, namely: (1) complications; (2) sequelæ, and to again consider under each division, its subdivision topically. Under the head of complications, in position of their greatest im-

portance, are peritonitis, abscess, obstruction of the bowel, gangrene, sepsis, phlebitis, hemorrhage and certain complicating diseases. Under the head of sequelæ we have adhesions, hernia, fecal fistula, constipation, pain and neurasthenia.

I have placed peritonitis first because it accompanies almost every case of appendicitis and is perhaps the most dreaded of the complications. For our purpose we can define peritonitis as an inflammation of the peritoneum, caused by bacteria or their products. It is well known that in peritonitis complicating appendicitis, sterile cultures have been obtained from the peritoneal fluid. This is probably due to the fact that the chemical products of the bacteria have transuded through the walls of the appendix and offended the peritoneum, the bacteria themselves not having actually invaded the cavity. The first change noted in the peritoneum is its congestion in the region of the appendix: it soon loses its shiny appearance, an exudate of fibrin and serum appear; as the case progresses the fibrin becomes organized and the serum turbid; finally pus is formed. The pus may remain free in the cavity or become walled off by the peritoneum; loops of intestine and fibrin, and an abscess results.

The symptoms are often introduced by a chill followed by fever, vomiting, hiccough, intense pain in the lower abdomen, tenderness, rigidity and later tympanites; although occasionally a case is seen in which the abdomen remains retracted and doughy. The sufferer tries in every way to lessen the intra-abdominal pressure, hence the legs are drawn up and the breathing is shallow. The temperature has but little relation to the severity of the case. The peritonitis is usually more localized than the symptoms would seem to indicate; frequently in a case following perforation, in which the symptoms would point to a general involvement of the peritoneum, the process localizes itself in a few days and we have a small abscess in the region of the appendix. Prolonged vomiting is one of the worst symptoms of peritonitis.

Perforation, as a complication of appendicitis, may be caused in one of two ways, or more often by a combination of the two: (1) by bacteria; (2) by mechanical means, as pressure from an enterolith. In either of these ways it may follow an ulcerative process or be caused by the rupture of an abscess. If the abscess is confined to the wall of the appendix, it may rupture externally without opening the lumen of the

*Read at the 140th annual meeting of the Medical Society of New Jersey.

appendix. Usually perforations take place slowly so that nature has time to prepare for them and prevent general peritoneal infection. The openings are usually small. The rupture is attended with great temporary relief of the symptoms; the sudden relief of pain in an acute appendicitis usually denotes either rupture or gangrene and is a sign of the gravest import. I often hear it stated that an appendix has been obliterated or sloughed off. This of course does occur at times, but is not in my opinion as common as is generally supposed. I have frequently seen at a secondary operation, an appendix with no induration or other gross evidence of past inflammation, after the most severe attacks, at times attended with perforation and abscess. We should keep this fact in mind when considering the advisability of interval operations.

Abscess is one of the common complications. For many years appendicitis was called perityphlitic abscess. An abscess may be due to a perforation or may be an advanced step in a peritonitis. Its walls are formed by partly organized fibrin, of an ashy color, holding together the appendix, mesentery, intestines, omentum or other neighboring structures. The contents may vary in amount from a few drops to many ounces. The pus is usually thick and the odor disagreeable. The abscess may be single or multiple; secondary abscesses may be found in almost any locality. In the majority of cases, however, according to Deaver, "it is possible to divide these abscesses with respect to their situation into four groups: (1) anteriorly; (2) posteriorly; (3) in the median line, and (4) in the pelvis." According to the same author, who quotes Sonnenburg's table of 424 cases, abscesses perforate the following tissues and organs in the order named: Abdominal wall, cæcum, peritoneal cavity, pleural cavity, colon, rectum, bladder, ileum and uterus. In my own cases I have seen an abscess drain through the umbilicus, perforate a bronchus, contained in the sack of an inguinal hernia and on several occasions drain through a bowel. Perforation into a viscus usually gives but temporary relief, as the drainage is necessarily imperfect. In a few cases, an abscess will sterilize itself and be absorbed. In one of my cases I found a large lumbricoid worm in the abscess.

Obstruction.—Intestinal obstruction is indeed a formidable complication. The obstruction may occur at almost any stage of the attack and, as a sequel, many weeks

after it. The chief causes are strangulation by inflammatory products and intestinal paralysis. The symptoms are: Constipation, vomiting, soon becoming fecal, distention of the bowel above the obstruction and pain; the latter is often not severe at first. Intestinal paralysis comes on late in the attack and practically all with this complication die.

Gangrene.—The destruction of the entire appendix and portions of the cæcum by gangrene is not rare. It occurs in two ways; either by an inflammation so intense that the part is destroyed, or by obstruction to the blood supply. The first class of cases constitute the so-called fulminating group of appendicitis; the course is rapid and the mortality high. It is largely this class that furnishes the sudden deaths. The symptoms are: Sudden attack of excruciating pain, vomiting, rigidity, tenderness; then sudden relief of pain.

Sepsis.—I have already spoken of peritonitis and abscess; these may be local or a part of a general sepsis. From the standpoint of blood infections, sepsis, as a complication of appendicitis, differs little from sepsis occasioned in any other way; sapræmia, septicæmia and pyæmia are all seen. More or less septic intoxication is present in every case, but fortunately blood infections and the virulent types of intoxication are not so common as they were before the time of early operation and intelligent drainage. Septic inflammation of the vessels may follow appendicitis; it is usually a part of a general pyæmia, often the starting point of it. A primary or secondary abscess may be located near a vein or artery of considerable size, as the iliac or hepatic. If they ulcerate into these vessels, hemorrhage, various metastatic processes and pyæmia result. I have recently seen two cases of hemiplegia follow operations: one, in a septic case, occurred at the time of the operation, and the other followed several days after a gall bladder operation that ran an aseptic course. A non-septic phlebitis of the iliac vein occasionally follows an operation for appendicitis.

Complicating Diseases.—A person suffering with almost any disease may develop appendicitis and conversely, persons suffering with appendicitis are, of course, not immune from other diseases, so that I will simply mention a few of the diseases that occur quite frequently as complications. It has been stated that 5 per cent. of all appendicitis cases have lung complications. Pneumonia may be caused by the anæsthetic,

by exposure during operation, or be septic in origin. Pelvic inflammations in the female may arise from an attack of appendicitis, or old trouble, in a quiescent state, may be lighted up; some of our gynecological friends, however, state that these complications are very rare. I am sure they have occurred in my own cases. Typhoid fever may be complicated with disease of the appendix, and if perforation of the appendix occurs, it is practically impossible to differentiate it from perforation of a typhoid ulcer. Tuberculosis is a very common complication. In a recent case under my care at the Cooper Hospital, miliary tubercles were found covering the appendix; the patient apparently made a good recovery, but in a short time the process extended to the lungs, and the wound, which had healed by first intention, opened several weeks later. Nephritis is another frequent complication.

SEQUELÆ.

Adhesions frequently follow appendicitis, particularly if the attack is severe and the operation late. Fortunately, many of them absorb. Adhesions, after convalescence, may cause pain, symptoms of indigestion, constipation or intestinal strangulation. I know of a lady, 80 years of age, that had obstruction of the bowel by an adhesive band attached to the appendix, thirty years after an attack of appendicitis.

Hernia.—Hernia commonly follows operations in which drainage is used; in other cases they are usually due to faulty closure of the incision. They frequently contain adhesions and may cause much discomfort.

Fecal fistula.—In my experience, fecal fistulæ usually close themselves, only a small proportion needing operation. The opening may be in any portion of the appendix or in the intestine remote from it; most of the openings are small. Pain after appendicitis is more often due to adhesions than to any other cause.

Neurasthenia.—It is not unusual for an attack of appendicitis, to which may be added the shock of an operation, to make a profound impression on the nervous system, and for neurasthenia to follow; but I suspect that in some instances the neurasthenia is primary, and the surgeon is led into operation in the hope of relieving his patient of pain and other symptoms that are really of neurotic origin. Undoubtedly a large number of post-operative sequelæ could be accounted for in the same way.

FOURTH PAPER

TREATMENT OF APPENDICITIS*

By F. D. Gray, M. D., Jersey City, N. J.
Surgeon to the City, Christ and North Hudson Hospitals.

In America, at present, the advisability of operation at some stage of appendicitis—or subsequently—is conceded by a large majority of the profession and laity. This same majority agree upon immediate operation in all *early* cases, barring some strong contra indication. The term early is preferable to the measure of a certain number of hours after the onset, and it indicates absence of complications, such as perforation, abscess; local, spreading or general peritonitis; infection of pelvic organs, or such systemic effects as septicaemia, pyaemia, pneumonia, etc.

A smaller but increasing proportion of the profession would defer operation in *late* cases where one or more of the above complications exist until the interval, which they believe will come about by means of preliminary treatment, popularly known as Ochsner's, because Dr. Ochsner of Chicago has more thoroughly and persistently than any one else practiced and publicly advocated its use. It is consistent also to speak of the Ochsner method as the *conservative*, contrasted with the *radical* plan of treatment, wherein immediate operation is done at any stage of the disease, when diagnosis is clear and the patient not moribund. Conversation and correspondence with other physicians have convinced me that a more or less hazy idea of Ochsner's concept of conservative treatment of appendicitis exists; some thinking that he decries all operations; others that he operates only during the interval; while not a few are unfamiliar with the details of treatment by which he expects to bring a complicated case to the interval, for what he considers a safe operation.

The limits of this paper prevent my presenting Ochsner's argument as fully as I should like. I am, therefore, compelled to abstract as briefly as possible a paper read by him at Chattanooga, October 14, 1904. He said in part: "1. The mortality in appendicitis results from the extension of infection from the appendix to the peritoneum,

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or from matastatic infection from the same source; 2. This extension can be prevented by removing the appendix while the infectious material is still confined to that organ; 3. The distribution or extension of the infection is accomplished by the peristaltic action of the small intestines; 4. It is also accomplished by operation after the infectious material has extended beyond the appendix and before it has become circumscribed; 5. Peristalsis of the small intestine can be inhibited by prohibiting the use of every form of nourishment and cathartic by mouth and by employing gastric lavage in order to remove any food substances or mucus from the stomach; 6. In this manner very dangerous cases of acute appendicitis may be changed into relatively harmless cases of chronic appendicitis; 7. In my personal experience no case of acute appendicitis has died in which absolutely no food of any kind and no cathartics were given by mouth from the beginning of the attack."

These constitute the nucleus of Ochsner's argument. He then makes the following suggestions, based on his arguments, for the treatment of appendicitis: "1. Patients with chronic recurrent appendicitis should be operated on during the interval; 2. Those with acute appendicitis should be operated upon as soon as diagnosis is made, provided * * * the infectious material is still confined to the appendix, if a competent surgeon is available." Thus far you notice that he agrees with the radicals, but he says further: 3. "In all cases of acute appendicitis, without regard to the treatment contemplated, the administration of food and cathartics by mouth should be absolutely prohibited and large enemata should never be given; 4. In cases of nausea or vomiting or gaseous distention of the abdomen, gastric lavage should be employed"; (Now, especially, he differs from those practicing radical methods); 5. "In cases coming under treatment after the infection has extended beyond the tissues of the appendix, especially in the presence of beginning diffuse peritonitis, conclusions three and four should always be employed until the patient's condition makes operative interference safe; 6. In case no operation is performed, neither nourishment nor cathartics should be given by mouth until the patient has been free from pain and otherwise normal for at least four days."

Now, as to Ochsner's statistics covering 1,000 consecutive cases, including seven fatal ones that died without operation. They are as follows:

	Cases.	Deaths.	Death Rate.
Chronic appendicitis or interval operations . .	540	3	.5
Acute appendicitis without perforation	255	5	1.9
Acute, perforated or gangrenous without abscess	55	0	.0
Acute, perforated, with abscess	117	4	3.4
Acute appendicitis with diffuse peritonitis . .	33	10	30.0
Total	1,000	22	2.2

This must be conceded as a remarkable showing for 1,000 mixed cases, and yet, in the approximate bearing and value to the general practitioner of medicine and surgery, one must carefully consider the fact that all were operated on by a surgeon of much more than ordinary ability (with well trained assistants) both in judgment and technic, all in the same hospital and under good surroundings. A comparison of work under such conditions with the results by more radical surgeons, who operate not only in one hospital but perhaps in two or even three, and in homes as well, with different sets of assistants—in many cases not accustomed to his methods of technic—can never be absolutely fair and may be very misleading.

Believing as I do that the chief issue regarding treatment of appendicitis to-day concerns the line of cleavage between the radical surgeon who would operate immediately all complicated cases (not moribund) upon satisfying the diagnosis—and the conservative one who would wait for the subsidence of acute symptoms, in other words the interval, I concluded to send a list of queries—to a considerable number of men—presumably representing both classes, to determine, if possible, the differential results. Through the courtesy of Dr. Ochsner I secured a list of about twenty surgeons, who, he assured me were using his method. Next I selected about an equal number whom I had reason to believe were treating such cases radically and sent to each the following printed form:

1. Have you ever given the "Ochsner" treatment of complicated appendicitis a thorough trial?.....
2. If so, in how many cases (exact or approximate)?.....
3. What has been your mortality rate (exact or approximate)?.....
4. How have the results compared with your other cases of the same character treated by radical operation?.....

5. If you have not practised the "Ochsner" method, what, in your judgment, are (briefly) a few of the most important features of the operative treatment of complicated cases, specially in presence of general peritonitis?

6. What has been your operative mortality rate (exact or approximate) in early, uncomplicated appendicitis?

7. The same in complicated cases?

Signature

and as a result of forty such requests I received eighteen answers, about equally distributed between the two divisions. I see no special advantage in mentioning names when I summarize briefly the results of my correspondence—though I do not consider it by any means of a confidential character. A source of disappointment lay in the fact, on one hand, that among the Ochsnerians (if I may coin the word) such small lists were given as a basis for conclusions—ranging from two to forty-seven. Again a large proportion were unable to give exact statistics. Further, two distinguished surgeons and authors who presumably use the radical method and could no doubt furnish valuable data begged to be excused. The largest number of cases reported treated by the conservative method as I have said was forty-seven, the smallest two. The surgeon reporting forty-seven cases said the mortality was practically nil and yet acknowledged two deaths—4.25 per cent. One reported twenty-five cases by the conservative method with ten deaths—40 per cent.; while his mortality in complicated cases by radical operation was only 8 per cent.

A report from the Carney Hospital, Boston, said that they had used the Ochsner method "in quite a number of cases," that the mortality in four hundred and fifty cases during the last two and three-quarters years—all stages and all methods implied—was three and one-third per cent. This again helps but little from lack of classification of cases, methods and mortality by each. Among the radical operators who reported death rate in complicated cases the mortality ran from 4.5 per cent. to 30 per cent. I judge that the surgeons reporting the larger percentage understood complications to mean only general peritonitis. The same class reported the death rate of early cases from .06 per cent. to 1.5 per cent. One said that he never operated *early*—only *abscess* cases. A distinguished surgeon of our State said that he had used the Ochsner method in three cases and all died, but he thought they would have been fatal under any treatment. He also said that he believed all cases of genuine general peritonitis died. John B. Murphy expressed the

same sentiment here, I think in 1901, at the American Medical Association meeting. Three years later he retracted, saying, that he had meanwhile operated six such cases with four recoveries. Most of the radical operators who replied to my questions agreed that immediate operation at any stage, where diagnosis was clear, removal of appendix, if possible (and it almost always is), irrigation with normal salt solution, combined with Fowler's position were the essentials—the worse the case the more rapid must be the work. Opinions differed as to the extent of peritoneal toilet advisable—also as to drainage. Several urged opium in conjunction with the above to quiet peristalsis, and I suspect this question has more merit than most of us allow. Many of the radicals were in line with all the essentials of the Ochsner method except the dictum of waiting for the interval. Personally I have no doubt that eventually mouth starvation, rectal feeding, gastric lavage, if indicated, and small saline enemata will be accepted as essential even in cases where the surgeon believes it either unwise or unsafe to attempt to wait for the interval.

From the foregoing I am forced to the conclusion that this very important question, which will probably outlast all others of differential treatment, viz., *immediate* versus *late* operation in complicated cases, will never be fairly settled until some competent surgeon with the opportunity to treat in some one up-to-date hospital a large number of appendicitis cases, shall, on at least 500 (or better 1,000) patients, practice only the conservative or waiting policy in complicated cases and then on a like number the radical plan. The alternative would be for two competent men to make the same comparison on the same number of cases under, as nearly as possible, the same circumstances and surroundings. A few words remain to be said about some of the technical details of the operation. Undoubtedly most surgeons now believe that invagination of the stump is the ideal method. To Seelig, of St. Louis, belongs the credit of reviving interest in the old method of ligation, amputation and cautery of the stump. He shows that it is equally safe, as free from subsequent adhesions, fistulae, infection, etc., as is inversion, and also avoids certain accidents, such as imbedding of the stump, where inversion was intended, with the possibility of intramural abscess of the caecum—also an occasional secondary hemorrhage from a small artery in the end of the stump not

controlled by the purse string of invagination—besides being a distinct *time saver*.

My first five hundred appendectomies (approximately) were done by the ligation, amputation and carbolic acid cautery method; my next two hundred (approximately) by invagination—while for several months past I have reverted to the old method with equally good results. In all circumscribed abscess cases it is of the greatest importance to safeguard the general peritoneum by introducing beneath the edge of the incision strips of iodoform gauze before spilling a drop of pus. If any rule can be formulated as to irrigation it would be: do a dry operation in all circumscribed abscess and localized peritonitis cases, relying only on sponging. In diffuse peritonitis flush thoroughly with salt solution and my experience would say search for pockets and break up adhesions as well.

In regard to the problem of drainage: beyond doubt, the peritoneum, after the bulk of infectious matter has been removed, is vastly more tolerant of the remainder than we formerly thought, as is shown by the number of infected cases recovering without drainage; however, the old adage "in case of doubt drain" is wise policy. The cigarette drain inserted well into the pelvis, with the patient in Fowler's position, is very effective. Multiple strips of iodoform gauze placed in various directions throughout the abdomen and pelvis produce copious drainage for forty-eight hours if the top dressings are frequently changed, and in my hands have apparently saved many desperate cases. This plan has worked too well for me to allow its abandonment in selected cases.

I desire in conclusion to thank those who have so courteously assisted me by information regarding their work.

DISCUSSION.

Dr. Ernest Laplace, of Philadelphia.—There is no royal road to the diagnosis of appendicitis. There is no symptom or set of symptoms upon which we can at all times depend. Dr. Dickinson stated a most important fact in this question, first demonstrated by Pasteur, that in a developing inflammation, micro-organisms do not maintain the same degree of virulence, but generally increase their virulence in the course of the disease.

When the appendix is blocked by inflammation, the germs located there behave so differently under different conditions, that no one can foretell the damage that may be done by them within twenty-four hours. The bacillus coli communis is most frequently found to be the cause of the trouble. Fever, rigidity, pulse, leucocytosis and pain, all vary in their course in different cases. At best, he that is most skilled in the diagnosis of appendicitis

can only say, "I think this is appendicitis, and I think an operation should be performed." One patient may be very sick, and have very little fever or rigidity; and another less sick, with much fever, pain and rigidity. Dr. Ochsner's treatment in its present application, does not solve the problem of diagnosis; in fact, it evades this question. It is an ideal post-operative treatment. The causes for which the Ochsner treatment was originally devised, were those of inflamed and erysipelatous appendix and neighboring structures, including the colon and ilium, without the presence of pus.

Being operated upon, these causes usually were closed, and the peritonitis progressed fatally. The absence of pus led to the presumption that the case was not serious. This was a great mistake; for such a case corresponds precisely to erysipelas on the outside; and its condition is much more serious than the development of a mere circumscribed abscess. Within the last five years, whenever I find the condition above described—that is, a thoroughly inflamed appendix, with redness of the colon and ilium, I carefully pack with gauze and drain for a week. This draining of the active infectious causes out of the abdomen has enabled me to subdue the inflammation and save the patient. There are no absolute scientific data to work upon. The operator's good judgment, based upon his experience, must be his only guide as to the time for operation. I still prefer the operative treatment with ample drainage at all stages of the disease wherever the least suspicion of disseminating sepsis exists.

Dr. George H. Balleray, of Paterson.—Dr. Hedges referred to the fact that Dr. Fitz brought order out of chaos, but he forgot to give credit to Melier of France who first drew attention to the differences between appendicitis and perityphilitis. The difficulty was in olden times that not enough attention was paid at that time by the profession to this subject, and only recently has it received the attention it was entitled to. Kelly in his book gives credit to Melier. He spread the knowledge of the pathological conditions found in the appendix. Dr. Hedges called attention to the fact that the disease was often overlooked; that is true, and particularly so in children. I saw a child five years old with an acute perforative appendicitis, with an acute purulent peritonitis, and where one was not able to make a positive diagnosis. I have seen two or three cases in which the physician made a diagnosis of ptomaine poisoning. In one case the abdomen was found to be full of pus. Her attending physician had not grasped the condition. This simply shows that we cannot always be sure of what we are dealing with although we may see much of the disease. One of the readers remarked that after operation some of the cases of appendicitis showed neurasthenic symptoms and thought possibly they might have been neurasthenic cases to start with. I think that is right. Those cases often have not appendicitis, although they are diagnosed as such, the pain being of such a character as to lead to error. Of course we all are liable to err in our diagnoses, especially in regard to the differential diagnosis of pelvic lesions in women and appendicitis. It is commonly the case that pelvic trouble is the original trouble and the involvement of the appendix is secondary. It really makes no difference however as regards treatment. As to the question of when to operate, it seems to me that depends upon the character of

the case. In acute perforative appendicitis and peritonitis, no time is to be lost; if the patient is to be saved an early operation is indicated. Thorough cleansing of the abdominal cavity and drainage should be done in such cases. Many a case of appendicitis is a law unto itself and only good judgment, based on experience, will enable the practitioner to avoid unnecessary, and therefore unjustifiable, operations on the one hand, and criminal procrastination, which may mean death to the patient, on the other.

Reports from County Societies.

HUDSON COUNTY.

August Adrian Strasser, M. D., Reporter.

The Hudson County Medical Society met on December 4th. Dr. F. D. Gray presided and a fair attendance was registered. Under the relation of interesting clinical cases, Dr. A. P. Haskings reported the finding at an autopsy of an unusually long and tortuous appendix vermiformis. It started at its normal site in the caput coli, crossed two loops of intestine, dipped backward and downward, having a total length, when free from adhesions, of twenty-five centimetres. Dr. W. F. Faison reported a case of apparent cholelithiasis. The patient had had three transient attacks of jaundice previous to this one, which was the most severe and accompanied by intolerable itching. Celiotomy revealed cancer of two-thirds of the common duct, no enlargement of the gall bladder, but an enlargement of the hepatic duct. It became a nice question to decide whether to sew her up or proceed. It was decided to do a complete Kocher internal choledochoduodenostomy; the duodenum was cut through, as was the head of the pancreas, by the Paquelin cautery, so as to get right into the common duct, the cancerous tissue was excised and the remnant of the duct fastened into the posterior wall of the duodenum. Patient has made a good recovery so far, the bile passing over its new course. Dr. George E. McLaughlin reported a rare case of true ovarian pregnancy. Diagnosis of ectopic gestation was made three weeks after the lapsed menstrual period. At the laparotomy a hematomatous ovary was removed and in its centre was found a three to four weeks embryo. Dr. Fraise reported attending in labor a woman who was six months pregnant, but looked way beyond term. Pains were normal up to delivery of the head, when in spite of violent expulsive efforts no progress was made. Traction on the head pulled it off. Arms were then delivered and traction in the axillae threatened to part the trunk. Help was summoned and suddenly, with a great gush of water, the body of the fetus was delivered. Examination showed that the enormously distended bladder of the fetus had caused the dystocia and its rupture had eventually allowed complete delivery. Dr. A. J. Rosenstein reported that in two new born children, one after footling birth, the other a normal L. O. A., vulvar bleedings occurred. He gave a favorable prognosis and was justified by the outcome. Dr. D. S. Hardenberg detailed a history of tetanus in a child six days' old; trismus, inability to nurse, a positive Kernig's sign was present, but no convulsions. Death. Dr. A. A. Strasser reported a case under his charge at the hospital. Child was taken sick with nausea and

vomiting and partial obstipation. Under outside attention child was treated medically and on admission to the hospital was suffering most from the effects of too many narcotics. Under dietary regimen and enemata the intestinal obstruction seemed to clear up for a few days, but she again developed a temperature and symptoms of obstruction, although no tumor was palpable and no bloody mucus stools were passed. She was laparotomized by Dr. Charles L. Ill and in the right iliac fossa was found the seat of the trouble, ileus caused by the appendix being looped around and constricting the ascending colon just above the caput coli. In freeing the adherent appendix the bowel was slightly torn and it was thought wise to drain. Child recovered, with a temporary fistula that healed spontaneously before her discharge from the hospital. Dr. Henry Spence related the sequence of the case he reported at the previous meeting in October, a case of simple anæmia, apparently deriving most benefit from ext. pancreatis. The improvement was transient, however, and the patient relapsed. Blood examinations showed a great diminution of the erythrocytes from former counts and in spite of all treatment patient eventually died. Epicritically it must be regarded, as a fatal case of simple progressive anæmia of eighteen months' duration. There was no specific history and the tests of the urine to establish pancreatic disease had been negative. In reply to the request of the president for a brief summary of these tests for pancreatic disease, Dr. McLaughlin explained that the general practitioner would hardly ever venture to make these analyses because of their tediousness and complicated nature. In a general way it was to attempt the determination of certain glyceroses in the urine and a decision is reached by watching how rapidly the so-called Robson crystals are dissolved in 33 per cent. sulphuric acid, whether or not we are dealing with the various pancreatic lesions amenable or not to operative interference. (An excellent resume of this question and these tests is found in the *Journal A. M. A.* April 9, 1904; pp. 982-983. Reporter). The results are by no means infallible. Dr. McLoughlin had made the tests in fifteen cases and had five positive results, corroborated by operation or ultimate result. Dr. Richard Kuehne reported a case of tetanus developing two weeks after trauma, patient had typical risus sardonius, partial opisthotonos and convulsions. Two injections of antitetanic serum were given. Bromide of soda and liquid nourishment were pushed. On the fourth day it was decided to use hot baths and hot packs; after one week's treatment he began to improve and went on to recovery. Dr. Rosenkrans reported that a man came to him for relief of "piles." Examination failed to show such and digital examination showed the presence in the rectum of a sharp object, which proved to be a fish bone two inches in length. On removal there was immediate relief. The physician had once before removed from the same site in another patient a piece of a broken meat skewer which the patient must have swallowed with his meat! Dr. E. L. Bull related that he had been called to a child who was apparently suffering from false croup with paroxysms that occurred in the daytime, too. During his absence Dr. Pyle saw the case and although temperature was 99°, and pulse 120, from the history expressed suspicion of diphtheria. Throat examination was negative and the diagnosis of laryngitis was maintained. However, the croup

continued and temperature rose to 103.4° and pulse to 140, and on suspicion, antitoxin, 3000 A. U., were given, resulting in a fall in the temperature and pulse rate and general improvement. Dr. Gray detailed the following interesting case. A man was arrested on the charge of drunkenness in the evening and was found unconscious in the cell in the morning, and transferred to the City Hospital. Examination revealed two minor abrasions on the arms, a broad one over the malar bones and a puffy contusion over the LEFT parietal eminence. Catheterization gave a urine of almost solid albumin. Pulse was of very high tension, forty beats per minute. No other symptoms until patient developed intestinal hemorrhages. The house-surgeon debated the advisability of an exploratory laparotomy, but this was abandoned. In spite of medication, exitus lethalis. Autopsy. Over RIGHT side of skull, a fissured fracture, from the petrous portion of the temporal upward to one inch from the longitudinal fissure; under this a thick heavy clot over the brain. Question was, what relation had brain lesion to the intestinal hemorrhages, as no lesions of the intestinal mucosa were demonstrated, although there was free blood in the intestinal lumen. Kidneys were practically normal.

Then followed the reading of the papers of the evening. The first on "Diet" by Dr. Hamilton Vreeland (which I forward), which was discussed by Drs. Rosenkrans and Sexsmith. The former pointed out that former habits and environment must influence special diets, and referred to Chittendon's dietary studies and on the caloric value of foodstuffs. Dr. Rosenkrans detailed how in student years he had lived for a period of two years on a diet of milk and grain foodstuff. Last summer, in order to bring his own body weight up, he had taken rest and a diet rich in fats and had succeeded. Dr. Sexsmith argued that the Government supervised and aided in many ways the cultivation and feeding of cattle and live stock, but did nothing for its human proteges; and the sins of commission were in reality sins of omission, inasmuch as most of the dietary errors committed in young children were due to a lack of instruction on the part of those in charge, and that this instruction should properly be given by the public schools in preference to other matters less important to the human race. The first part of this argument was refuted by Dr. Strausser, who pointed out that by the governmental experiment stations in the various State colleges, by the work of such men as Atwater, Bryant, Wiley, Chittenden and others, the Government was striving constantly to safeguard its human proteges as well, if not better, than its live stock, and that physicians, as a whole, did not take advantage often enough of these reports which, for a small cost or in some cases gratuitously, were sent out by the Documents department. Dr. McLoughlin also in the discussion pointed out that many of the questions arising over the process of digestion were ably solved in Pawlow's "Physiology of Digestion." Drs. Spence, Bull, Faison and Nelson also took part in the discussion.

The second paper of the evening on "Compound Fractures" was delivered extemporaneously from notes by Dr. Haskings and was very exhaustive and instructive, being a summary of personally tried methods, experiences and results. (The paper will be forwarded later). Dr. Spence opened the discussion, pointing out the effect of

age, general previous health and present environment on the outcome of compound fractures. Dr. Faison dwelt on the advisability of bone wiring and Dr. Baumann on the indications for amputation following compound fractures. He lauded the use of constant irrigation in some cases and reported cases to substantiate the good effect. Dr. Gray had only the multiplicity of antiseptics advised to criticise and felt that 70 per cent. alcohol was equal to them all. Harrington's solution would be intolerably painful if used in compound fractures.

Various other matters, such as the reports of the Committee on Tuberculosis and of the Committee on "Publicity" were listened to with interest. Dr. Spence, on behalf of the Legislative Committee, warned against sloth in the matter of osteopathic legislation if such arose during the next session of the Legislature again. After settlement of routine matters, the meeting adjourned and the members partook of the refreshments prepared.

MORRIS COUNTY.

H. W. Kice, M. D., Secretary.

The Morris County Medical Society met at the Mansion House, in Dover, December 11, Dr. W. J. Wolfe, of Chatham, presiding. Dr. P. A. Harris, of Paterson, gave a very interesting review of appendicitis and how to treat the acute conditions, emphasizing the danger of interfering, with the knife, too early. Dr. Levi Farrow opened the discussion on Insurance Examination Fees in a brief paper, which I enclose. In concluding his remarks Dr. Farrow moved that the secretary write to the president of the Medical Society of New Jersey requesting the president to appoint a committee of five who shall prepare and issue a statement to the public on this question. This was done in compliance with a suggestion of the Publication Committee and the editor. (See JOURNAL December, page 160.)

A committee, consisting of President Wolfe and Treasurer Douglas and the secretary, was appointed to arrange for Dr. McCormick's meeting in February. The next meeting, the annual, will be held in Dover. Arrangements are being made by Dr. Harvey, the councilor for this district, through the committee of the Morris County Medical Society, to have Dr. McCormick's meeting in Morristown on Saturday, February 2. Two meetings will be held in the afternoon, one for physicians only and one for the public.

NEW MEMBERS OF COUNTY SOCIETIES.

Atlantic County: A. L. Atherton, Samuel Barbash and T. L. Githens, all of Atlantic City.

Middlesex County: Norman N. Forney, of New Brunswick.

A communication too late for this issue has been received from the chairman of the Board of Councillors relative to the address of Dr. J. N. McCormick before the county medical societies of New Jersey. The dates and places of meeting thus far fixed are as follows:

February 2—Morris County Medical Society, at Morristown, N. J.

February 4—Warren County Medical Society, at Belvidere.

February 5—Sussex County Medical Society, at Newton, N. J.

ADDRESSES ON MEDICAL TOPICS.

The following addresses will be delivered before the William Pierson Medical Library Association:

Tuesday, January 8th, 1907.—Dr. Alexander Lambert, New York City, "The Possibility of Diagnosing the Various Lesions of the Cardiac Muscle."

Tuesday, February 12th, 1907.—Dr. George Emerson Brewer, New York City, "The Diagnosis and Treatment of Certain Acute Unilateral Infections of the Kidneys."

Tuesday, March 12th, 1907.—Dr. John R. Shannon, New York City, "Errors of the Refraction and Balance of the Eyes, and Their Influence on the General Health."

Tuesday, April 9th, 1907.—Dr. Sinclair Tousey, New York City, "The X-Ray, the Ultra-Violet Ray and High Frequency Currents in Diagnosis and Therapy, Illustrated by Apparatus."

Tuesday, May 7th, 1907.—Clinical Night.

The profession generally are cordially invited to attend. Hour, 8.15 P. M.

The Essex County Medical Society has made arrangements for a series of lectures to be delivered before its members and other medical practitioners during the ensuing three months, by members of the profession, as follows: January, Dr. William M. Polk, of New York City; February, Dr. T. H. Musser, of Philadelphia; March, Dr. A. J. McCosk, of New York City. The exact dates, place and subjects will be announced later.

LETTER FROM PRESIDENT MARCY.

We have been requested by President Alexander Marcy, Jr., of the Medical Society of New Jersey to insert the following letter in this issue of the JOURNAL. We are not only pleased to comply with the request, but also to give it the prominent place its importance demands.

TO THE MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY:

I am sure you all are deeply interested in the question of an organized profession, and are willing to assist in any way that you can the efforts that are being made to enlarge the membership of the component societies. It is unnecessary for me to tell you why organization is essential to the best interests of our profession, or attempt to point out to you the many advantages arising from such a condition. You are already familiar with what has been done along these lines, and can readily see how much more can be accomplished in our own State by a united and thoroughly aroused body of medical men.

There are a great number of men in New Jersey who are not, but who ought to be, members of our component societies, and

in order to acquaint them with the necessity, as well as the benefits to be derived from membership, it has been thought advisable to have Dr. J. N. McCormick, National Organizer of the American Medical Association, to visit us and make a thorough canvass of the State.

Dr. MacCormick will begin his work here on February 1, and will visit every component society in the State. His plan is to hold meetings at some central point in a county or city, in the afternoon, to which only members of the profession shall be invited, and in the evening of the same day to have another meeting, to which prominent laymen, as well as medical men, shall be invited.

The details of Dr. MacCormick's visit will be arranged by the councillors of our State society, who will in due time issue a statement regarding this important matter. I simply wish at this time to bring to your notice the fact that we are to have this opportunity of meeting and conferring with Dr. MacCormick and hope that you will endeavor to secure the hearty co-operation of every member of our society in making this visit both pleasant and profitable.

This will be the greatest opportunity the medical profession of the State has ever had, and, if we make of it all that we should, we will find ourselves wonderfully strengthened and encouraged in our battle against fraud, quackery, the nostrum evil, etc. We will be able to successfully oppose vicious legislation. We can hope to so influence public opinion, that it will always be found on the side of right, and we can secure such an uplift for ourselves as will make of us better citizens as well as better physicians. Faithfully yours,

ALEX. MARCY, JR.

Riverton, N. J., Dec. 21, 1906.

The young man should learn of his obligations, and of the good to accrue to him and his patients by joining organizations which may help him. The low state of the profession in the esteem of the public is really remarkable in view of the high opinions held of its individual members. It is because the organization is a frail weakling contemptible for its weakness, but just growing into power. When the organization is complete, we may rest assured that its sanitary suggestions will be heeded and public health increased. It is a public duty to strengthen any organization capable of so much public good.—*American Medicine.*

THE JOURNAL

OF THE

Medical Society of New Jersey.

JANUARY, 1907.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any one failing to get the paper promptly will confer a favor upon the Publication Committee by notifying them of the fact.

All communications relating to the JOURNAL should be addressed to the Committee on Publication, 95 Essex Avenue, Orange, N. J.

GREETING.

As we stand on the threshold of a new year, the editor extends to the members of our State Society and other subscribers his most sincere and hearty wishes of a

HAPPY NEW YEAR

in their own personal experiences and in their professional associations; that they may achieve the highest success for themselves individually and contribute to the greatest prosperity of our Society, through their fidelity in upholding the honor and dignity of the profession and in contributing to its scientific advancement.

Recognizing the assistance rendered him during the past six months by some of the Reporters and Secretaries and a few other members of the Society, the editor returns sincere thanks to them, and will be pleased to have many more unite with them in the effort to make the new year a happy one to him by furnishing such personal and Society news items and reports of scientific investigations and discoveries as will help to make our JOURNAL more interesting and profitable to us all.

RETROSPECTION.

Time has brought us again to that period of the year which calls for retrospection, and from that to the endeavor rightly to estimate present requirements and to make decision as to our future in so far as it lies within our power to forecast and determine

action. It has been our desire and endeavor to make this JOURNAL worthy the society it represents and that has presented us an ideal in journalism which it has been impossible to attain. Deeply conscious of the fact that we have come far short of perfection, we can only plead the limitations of human endeavor toward the attainment of high ideals, amid other exacting duties in this strenuous age, as our excuse. We are, however, stimulated to further and better endeavor by the fact that we have a standard yet to be attained that is worthy our best effort in a profession that is most honorable and serviceable to humanity, and for a Society, that for age, worthy and faithful membership and most creditable work and achievements, has been second to none in the country.

In reference to the past we briefly refer to a few of the principles that have actuated us and which will characterize the future conduct of this JOURNAL. The editor has not sought to conduct it as his personal organ, or to use it in any way for the setting forth of his personal opinions in matters on which there is decided variance of opinion; his name even does not appear in its monthly issue. It is the organ of the Society and it has been his endeavor to voice the general opinions of its members and if there should be occasion to doubt his faithfulness in representing them correctly, the columns of THE JOURNAL have been open for their criticism. That this endeavor has been at least partially successful, the editor modestly believes from the fact that he has received no communications taking him to task for the attitude of THE JOURNAL toward matters which involve the honor of the profession and its attitude toward other organizations and the public welfare, e. g., medical insurance examiners' fees, nostrums, contract practice, the admission of unethical or questionable advertisements, or the use of improper methods to secure them, etc. If there has been occasion for criticism, not expressed, he gratefully returns thanks for the forbearance exhibited.

We express our thanks to our sister Societies' and some independent medical jour-

nals for their approval of our position. We cite but one—that of the *Critic and Guide*, in its December issue, referring to the improper bidding for advertisements that is indecent and savors of blackmail, which it severely rebukes, and says: “Nastiness is nasty whether it occurs in the *Medical Brief* or in an official State journal. And the better class of official editors will agree with us. I know that the editors of the New York and New Jersey State journals will.” The editor of this journal certainly does, and it will continue to be his effort and that of the Publication Committee to issue a *clean JOURNAL*, shutting out such nostrums or frauds as antikamnia, peruna, mandragorine tablets, etc., and admitting only such as we can commend as ethical, even if the Society pays every dollar of THE JOURNAL’S cost out of its treasury.

During the year 1906 our Society lost many of its faithful members whose names we have recorded among our departed but not forgotten members, and of whose faithful work we have spoken. Some of the fathers who have long and faithfully served, others who were just beginning or were in the midst of the activities of professional life which gave promise of years of successful work to the honor of our profession. As we close the year our honored ex-president, Henry W. Elmer, still lingers amid the shadows, beyond the power of our healing art to restore and we can only tenderly commit him to the care of the Great Physician, whose “well done” will mean to him infinitely more than any encomiums from human lips or hearts, as He shall usher him into that realm where sickness and pain shall never be known.

We have been glad to welcome a larger number of new members than in previous years and the profession has been better organized and more united than ever. This has been manifested in the work of our Society—we believe we can affirm that better and more scientific work has been done than ever. The last annual meeting was, in the

number and value of the papers presented and the discussions, considerably above the average. There has been more interest in, better attendance on, more scientific papers presented in our County Societies, and there is a tendency toward better organization as a rule, though we are constrained to believe that there is great need of more decided effort on the part of the individual members to organize and unify the profession, in most of the counties.

More interest has been manifested in the cause of preventive medicine on the part of our members, through the work of the State and local boards of health; in the formation of the State Anti-Tuberculosis Association during the past year on whose board of directors are several members of our State Medical Society; also in the New Jersey Sanitary Association in which many of our members are active; also in the work of our Committee on Legislation that has done its best work in upholding a high standard of medicine, and in opposing the nostrum evil and other forms of quackery—all in behalf of the public welfare.

Our lack of space forbids us from particularizing on the advance during 1906 in the various departments of our profession. We can only say that there has been very decided progress made, through scientific investigation, toward solving the many problems that have perplexed the profession concerning the etiology, pathology, diagnosis and treatment of disease, and especially in surgery and gynecology. We believe that one of the most hopeful signs of further progress has been in bringing the general practitioner and the specialist into more practical accord as each recognizes more properly the sphere of the other and is led to work in more hearty coöperation, as they both alike recognize the need of that co-operation for their mutual good and the saving of human life.

The year 1906 has awakened the profession to consider its needs. Let 1907 be marked by vigorous UNITED ACTION in asserting and maintaining its RIGHTS.

THOUGHTS FOR THE NEW YEAR THAT CALL FOR UNITED ACTION.

"In Union There Is Strength."

The organization and unification of the profession should be the first pressing duty that appeals to us as we enter upon the new year. As we have before urged in these columns, our members should recognize the fact that our profession has lost to a considerable degree that respect *which is its due*, and this condition is very largely owing to the neglect of its members to act worthy of it.

The petty criticisms leading to strained relations between members has been due often to a selfish ambition to succeed even if a fellow-member thereby unjustly suffers loss of business and public esteem, and the results have been lessened confidence of the public in the profession as a whole, and the increasing use of nostrums, the many new delusive and false systems of practice and the large number and influence of quacks. Then we have foolishly allowed organizations and wealthy corporations to force upon us their estimate of the value of the physician's or surgeon's services, and that has developed the iniquitous contract system of practice which has grown to enormous proportions when there is no possible justification for this indignity. Think of it—a railroad company securing a thousand dollars or more of service for an annual pass; an order or society paying a doctor a dollar a year for attendance on a member, and, in some cases, on his family; an industrial corporation employing a cheap doctor to attend its employees gratis, thereby robbing the other physicians of a community of many of their patients: lastly, but not least, the insurance companies, with tens of millions of surplus, paying enormous salaries, dictating, and now attempting to form a gigantic trust to compel their medical examiners to take for their services the pittance they will condescend to offer. (See article on Medical Examination Fees on another page.)

Members of this great Medical Society of New Jersey, think of the honored names of the past, of the wonderful record of honorable, faithful service of country and humanity! Shall we show ourselves "worthy sons of noble sires" and, following their example, dare to stand together for the right—for the manly maintenance of the honor of the Society, the dignity of our profession and the self-respect that we should maintain as worthy members of such a Society and such a profession? Or shall we lower our standards—surrender our rights and our manliness to the enemy and accept such terms as may be granted? Then we would have no just cause to contend against quackery—we would all stand on common ground and, alas! the public will be worse off than the doctor, for he would probably become a servile politician. The gigantic corporations and the Mutual Trust Graft Insurance Companies may then all combine, more easily buy legislatures and congresses, and the wage-earners, including the non-political doctors, will be at their mercy. Let us seriously consider these questions, so vital to the future welfare of both the profession and the public. Can we recommend young men with noble ambitions, at such great expense of time and money as is now required, to study for and enter the profession, under such present conditions and tendencies as we have considered? It is a question whether we ought to do so unless they are young men, of sufficient wealth, who could, and would be willing to, practice at a loss, if needs be, for the sake of suffering humanity. The year 1907, we believe, will largely determine the status of our profession and the respect of the public for it—including the men who are now treating it with indignity (for they will really have little respect for the cowardly surrender of manhood). If our contention is not *just*, if argument can prove us in error, then we will, like manly men, reconsider our position. We only desire what is *right*, and there has been presented no argument to shake our faith in the rectitude of the course that this and

other journals have taken. Let us UNITEDLY stand for the RIGHT, and we can afford to be regardless of consequences—for RIGHT makes MIGHT and will finally prevail.

Another needed reform of vast importance which should receive serious consideration as we begin a new year, and concerning which immediate and persistent action should follow as a result of right thinking, is in reference to the Nostrum Evil and the advertising of quacks and "patent medicines" in the religious and secular press. We print elsewhere in this issue two excellent editorials from the Journal of the American Medical Association. We ask our subscribers to read them carefully and then ask two questions: (1) How far am I responsible for the increase of these evils? (2) What can I do towards their eradication? We venture to suggest a few thoughts for consideration to help in answering these queries. First, and most important is the fact that the "nostrum" or "patent medicine" evils would never have attained one-tenth the present proportions if physicians had not extensively used them. Druggists have informed the writer that a large proportion of prescriptions received from regular physicians were for these preparations. The writer never gives a prescription for any of them. If he has reason to believe, from a knowledge of their composition and the proportions of their active ingredients, that any of the better class of so-called "patent medicines" are indicated, *in a given case*, he never gives them in the "original package" with their labels on or names blown in the glass. Why? Because the patient can subsequently go to the druggist and have the prescription repeated again and again, when in many cases, he needs an entire change of medicine, and because the said patient will recommend to her friend whom *she thinks* is suffering from the *same* ailment the medicine that has helped her, with the result that the friend is worse rather than better from its use. She was not suffering

from the same ailment. The medicine was not what she needed; patient No. 1 was not a scientific practitioner, but acting the part of a quack and her physician, who *was* a scientific physician, suffered in the esteem of patient No. 2. As we are considering the question from the ethical view-point—of the physician's responsibility, we will not enlarge on the fact that both these patients' physicians lost fees through the "patent medicine" prescription, though the physician who gave it would doubtless be the greater loser, for every time his patient had a similar attack he would go to the druggist rather than to his physician. Then again, in the counter-prescribing business, the druggist will recommend this or that "patent medicine" saying "Dr. So-and-So often prescribes it."

If the physician is a scientific practitioner he should write his own prescriptions, adjusting the ingredients and their proportions according to the requirements of the individual case. January 1, 1907, is a good time to cease playing into the hands of the "patent medicine" manufacturers and the constantly increasing number of "Chemical Graft Companies." Not because we suffer financially, but because it is not practising scientific medicine. It is not for but against the public good, it tends to destroy rather than save life. Then—for these reasons, we *can* consistently, we *ought* to fight and overthrow this gigantic evil.

In reference to the advertising of Quacks and Nostrums in the press we recognize the good work that Collier's Weekly, Ridgway's Magazine and the Ladies' Home Journal have done and are doing in showing up the deception and fraud practiced by these conscienceless quacks and nostrum manufacturers and venders; their lying claims and false certificates with cuts of brazen-faced men and women ad nauseum; some of whom are myths and many of whom have been bribed. It is bad enough in the secular press, but far worse in religious papers to sell for a few paltry dollars, their reputations as the advocates of TRUTH and RIGHTEOUSNESS, while they

become particeps criminis in the deceptions and frauds practiced and the resulting poverty—through swindling, intemperance, mental obliquity through opium habit, etc., and loss of health and life.

The people need education on these subjects. They should be shown by argument and illustration the character of these men and the far worse than useless effects of these nostrums, and that our opposition to these enemies of the people's social, mental and physical welfare is rather against than for our own financial interests. Let us as physicians realize our responsibility and speak out in public and private, and call the attention of editors, especially of the religious press, to the enormity of these evils and to their responsibility as public educators.

LIFE INSURANCE COMPANIES THAT ARE NOT SEEKING CHEAP MEDICAL EXAMINERS.

We herewith publish a list of the life insurance companies paying a \$5 flat fee, as far as known to us. If our readers know of others they will please inform us:

Ætna Life, Hartford, Conn.

American National Insurance Co., Galveston, Texas.

Citizens Life, Louisville, Ky.

Capital Life, Denver, Col.

Fort Worth Life, Fort Worth, Texas.

Manhattan Life, New York City.

Massachusetts Mutual Life, Springfield, Mass.

Mutual Benefit Life, Newark, N. J.

National Life, Montpelier, Vt.

Northwestern Mutual, Milwaukee, Wis.

Pacific Mutual Life, San Francisco, Cal.

Provident Life and Trust, Philadelphia.

Reliance Life, Pittsburg, Pa.

We believe these companies are thoroughly reliable, that they do not pay their officers excessive salaries, and are not mixed up with trusts or political parties. They should be favored in every way possible by the members of the medical profession.

Dr. Randall, Medical Director of the American National, in a letter stating that

the company has adopted the \$5 fee, says: "*It is the desire of this company to employ only the best examiners, and they realize they can only get good men by paying a reasonable fee.*"

That is good common sense and shows that this company is run on sound business principles.

Apropos—We note at the head of an advertisement in one of the State Medical Journals the following: "No Yellow Dog Funds, No Campaign Expenses nor Contributions, No Officers with \$100,000 per year Salary."

PRIZE ESSAY.

This prize was instituted by the Medical Society of New Jersey at the annual meeting in 1905, and is open for competition to the members of the Component (County) Medical Societies.

The subject chosen is "The Symptoms, Etiology, Pathology and Treatment of Pneumonia."

The essays must be signed with an assumed name and have a motto, both of which shall be enclosed in a sealed envelope containing the author's name, residence and component society.

The essay shall contain not more than 4,000 words, and must be characterized by originality in investigation and thought, and by clearness and conciseness of expression, and be, in the judgment of the committee, of decided value to the members of this society, and to the profession generally. Failing in these respects, no award will be made.

The essays, which should be type-written, with the sealed envelope, must be placed in the hands of the committee on or before the first day of May, 1907.

The committee will select the first two essays in order of merit. To the first will be awarded the prize of one hundred dollars, to the second that of honorary mention.

The unsuccessful authors will receive back their essays upon their identification to the chairman of the committee. The successful essay will be the property of the society and be published in its transactions.

CHARLES J. KIPP, Newark, *Chairman*.

WALTER B. JOHNSON, Paterson.

DAVID C. ENGLISH, New Brunswick.

Committee.

INSURANCE MEDICAL EXAMINERS' FEES.*

By Levi Farrow, M. D., Hackettstown, N. J.
Mr. President and Gentlemen:

I have been asked to open the discussion on the subject of "Fees for Medical Examinations of Applicants for Life Insurance." I do not know that I have anything new or additional to offer than that contained in my recent paper on that subject, read before this society. In fact, to me the subject needs no special defence, from a medical examiner's standpoint, as the other side has no argument in equity or in fact. But even if it were different, the vast majority of physicians are already beyond the stage of argument and are already lined up in solid phalanx against the contemptible proposition of some of the insurance companies, waiting in dignified humiliation, if not disgust, for the hypocritical, mercenary "other fellow" to grow sense. For the proposition is humiliating, and it is purely mercenary and to all intents and purposes hypocritical on the part of the proposers, and cannot, with any consideration of merit or the fitness of things, be galvanized or boosted up into the realms of profitable argument. I say already the profession—as one man almost—has made up its mind. It is true that at first the very impudence of the proposition nearly paralyzed and "knocked the pins" from under many of us, but when we got our "second wind" it did not take long to assume the perpendicular—and there we "stand pat." Like the story of the minister and his prompt settlement of a desirable pastoral call: when the little Miss of the Manse was asked if her reverend papa had accepted, she said, "I guess we have—for while papa is in the study praying about it, mama is down stairs packing the goods to move." In like manner the average astute physician has already "packed the goods." There is no other course consistent with self-respect, and if there is any righteous argument on the other side we have failed to discern it and hope it will be brought out to-day. On the other hand, the request on the part of the said insurance companies is not only unjust to us, but worse than ungenerous in a mutual business pact. It is not only positively humiliating, but absolutely "rotten" to any self-respecting physician, in the light of all the facts, and is he wise or alert in business morals or equity if he dignifies the affront by raising it to a serious argumentative basis?

Dignified resentment should be his attitude, especially in the light of the rotten methods uncovered and confessed by the party of the first part—who are the principal offenders in the offensive proposition. Reputable companies that keep no "Yellow Dogs," to sport with at policyholders' expense, do not find any trouble to make ends meet and are not howling for the examiner to divide his very reasonable fee with high-priced and too often nefarious officials. Not a single protest has come from policyholders, only or principally from the grafters and self-confessed spoilers of widows' and orphans' trust funds. Do not be deceived. It is the same old gang yet, not even whitewashed, only with a new label. True repentance is always accompanied with restitution, and then regeneration follows or is possible, but they have the goods on 'em yet, and are said to be pilfering still. Oh, no! this seeming economic spasm is not a sign of repentance, nor judicious expense retrenchment, nor systematic of the growing of a better business morale—it is only "de same old gang," "throwing a fit" to, if it were possible, deceive the very elect. The principle of economy that "robs Peter to pay Paul"—why, that's different. Other reputable companies deem it no hardship to do a profitable business with fat dividends reverting to policyholders without mulcting us and yet have not the boasted surplus of these Wall Street speculators, who would increase their illegal private gains a little more at the expense of the M. D. who is the important unit which intermediates between an honest risk and safe business, or a happy-go-lucky or wild-cat scheme. They even threaten to dispense with medical examinations. Well, let them! So a wagon could dispense with its linch-pin and wobble along more or less indefinitely, but would come to the ground in due time all the same, and smash things.

The service which these traffickers in trust funds and lives ask for actually requires a very high degree of scientific equipment, first-class judgment and decision regarding past, present and future probabilities concerning each individual case examined. Examinations are not always nor generally at the examiner's option nor convenience. Surely it is worth half the fees at least that an average horse doctor would demand for sizing up the good, bad and indifferent points in the anatomy and speeding ability of a \$200 or \$300 horse. The purchaser would call a \$10 fee for such O. K.'ing "dirt cheap." Yes, as the *Texas State Journal* says: "The companies *can* pay \$5, the phy-

*Read before the Morris County Medical Society.

sician earns it, the policyholders are safer when it is paid." Then let us make them pay it, not as an arbitrary demand, not as our share of a lucrative business, but to be paid like a good note—"for value received, without defalcation or discount." It is well to consider this matter as a society, it is better for each member to settle it for himself. Let him say that as for him and his house, we will serve the Lord and humanity without money and without price if necessary, but we won't serve life insurance companies for less than \$5 per examination.

I would call attention to the suggestion made in the December number of our State Medical JOURNAL concerning action along this line, which I will read.

MEDICAL EXAMINATION FEES.

We do not usually take up editorially the controversies of our contributors, but we cannot refrain from a few words on this important subject, as we do not wish the impression to go out that the *Medical Council* is in favor of the reduction of fees. Our every utterance has been for the higher fee, and we have only allowed other views to appear because we do not want to suppress freedom of expression.

The argument is often made against physicians taking action in this and other matters relating to their welfare in their organized capacity as medical societies, that it looks like trade-unionism. We know of nothing more in favor of our united action than that same accusation. A glance at the condition of wage-earners in countries having no trade-unions will be sufficient. The union is the only thing in this country that stands between the worker and starvation wages—say fifty cents a day. It enables him to have a home and family and to educate his children. Mistakes are made in unions—and so are they in the United States government! So they are in all human organizations, especially in their process of development. We are wage-earners, and we have a right to unite in protecting our interests. If the insurance companies can only get us divided and competing with each other it will be but a short time until the fees will be down to one dollar—plus the "honor" of having our names quoted as examiners for the "Mutual Graft Insurance Co."

The claim that a person would be deterred from taking a policy in a company because its examination fee is \$2 more than that of another is too absurd for consideration. He would, however, between two companies, choose the one that is known to have the best examination. In all this controversy about economy we have not heard a single reply to the question why the companies do not begin by cutting down the salaries of the men whose administration has made the economy necessary—the officials—to a reasonable salary—say equal to that of a United States Senator or a Judge of the Supreme Court.

We have noticed that there is not an honest company in the cutting list; they seem all to have been participating in the infamous tontine gamble or other irregular work. Every one of the companies that really deserve the policy-holders' confidence is now in the five-dollar class. The doctor

can do some good missionary work by promulgating a few facts among his clientele.

Lest it be suspected that the writer of these few lines has only a theoretic knowledge of what he is writing about, he may be allowed to state that he once made a test of his own work, keeping a list of 300 applicants approved by him for one company in a period of over two years (those rejected not followed up), and at the end of ten years there had not been a death among the 300 accepted. This is the first boast he has ever made in these columns, and he hopes never to make another one. So far as really careful work is concerned, it is more nearly worth to the company \$100 a case than careless work is worth \$1.

Reference is very appropriately made by the three-dollar defenders to the work the doctor does for railroads and industrial corporations at cut rates. We most heartily agree that there is no possible justification for this either, and that is the very next subject we intend to take up. You may look for something lively in these pages in the next few months.—*From Medical Council.*

Nostrum Advertisements in the Religious Press—Now that many newspapers are refusing advertisements of questionable proprietary medicines, it may not be amiss to call attention to the shortcomings of another class of journals in which these advertisements are more or less prominent, namely, the religious and semi-religious publications. *A priori* it might be expected that publications of this character would exclude from even their advertising pages any statement which was obviously lacking in truth, so far as human experience is able to judge of truth. A glance over the advertising pages of the available religious and semi-religious journals shows that this is far from being the case. Discrimination must be made, however, between certain high-class theological publications and semi-religious journals (as the *Outlook*, for example) on the one hand and the cheaper weekly semi-religious sheets on the other. The former are clean in their advertising, the latter are far from being so.

The class of medical advertisements contained in the ordinary religious weeklies does not differ greatly from that found in the daily papers. Aside from the legitimate medical advertisements, two classes are to be noted: first, those claiming to cure incurable diseases and, second, those whose claims are obviously exaggerated. It will hardly be credited that, after *Collier's* exposure of the vampires who fatten on the credulity of the unfortunate cancer sufferer, any decent paper, much less one of religious tendencies, would publish the advertisements of this shameless crew. Yet we find in the pages of the *Episcopal Recorder* of Philadelphia a statement in flaring type, "Cancer Cured by Soothing Balm Oils." This emanates from the notorious "Dr." Bye of Kansas City, and, indeed, both this "Dr." Bye and the "Dr." D. M. Bye of Indianapolis are represented in this journal. A similar "oil cure" for cancer, by one "Dr." L. T. Leach of Indianapolis, is to be found among the advertisements of the *Advance*, a Congregationalist journal published in Chicago. Such advertisements are not only palpably false, but actually cruel, and, published in the pages of journals which are supposed to stand for the Christian principles of rectitude and truth, are doubly worthy of condemnation. Hardly less despicable are other advertisements heralding the sure cure

of incurable or very intractable diseases, like heart disease, asthma, or baldness. What should be thought of a religious journal (the *Westminster*) which published the statement that "on the very first indication of heart disease you can stop all progress and effect a cure by the use of Dr. Miles' Heart Cure"; or of another (*Western Christian Advocate*) which states that "magic foot drafts possess the remarkable power to compel the system to yield down through the great foot pores the impurities which cause rheumatism, relieving where everything else has failed?" These are the most glaring examples, and the papers mentioned are the most flagrant offenders, but by no means the only ones. One journal cites on one page a reference to Isaiah, giving the prophet's remarks against the use of alcoholic drinks, while on another page it advertises a notorious sarsaparilla which contains 18 per cent. of alcohol. A journal which, with evidently human motives, advertises a fake cancer cure, decries on another page the fact that "the divine motive, once so great and effective an appeal, is set aside for the human motive," a fact of which any one who perused its advertising columns would be convinced. Another journal, the *Cumberland Presbyterian*, in one issue has an editorial on the evils of drink, and in the next issue an advertisement extolling the virtues of wine of cardui. This journal also carries an advertisement of Mrs. Winslow's soothing syrup.

Why does such a condition of affairs exist? Doubtless it is partly the fault of the medical profession who, until recently, have countenanced equally unvarnished advertising in their own papers. Partly, perhaps, it is due to the optimism cultivated by religious training. We fear, however, that it is mainly the result of the application of the so-called business principles to the conduct of religious journals. While the application of true business principles to the affairs of religious journals is worthy of nothing but praise, we fear that the publication in their advertising columns of absolute falsehood or perverted truth can not be considered as coming under this head. Let us hope that when these matters are brought to the attention of the proprietors of the journals mentioned they will see them in their true light and will institute reform.

Exposure of Quackery Doing Good—Mr. Samuel Hopkins Adams, who is now editor of *Ridgway's*, evidently has not lost his interest in the fight against "patent medicines" and quack doctors. Two weeks ago we referred to the splendid work that the *Cleveland News* was doing in showing up the quack doctors of Cleveland, and Mr. Adams has written to the *News* congratulating that paper on its work of exposure. He says: "If newspapers in other cities would turn the fire of their guns on these rascals their activity would very soon end. As it is, you are doing a very great work for Cleveland, which is, of course, your object, but, perhaps, indirectly an ill service for other cities, for the flock of vampires whose roosts you have disturbed will hover for a time and then scatter and settle in various parts of the country. It is a pity that there is not in every one of our larger cities some paper courageous enough to undertake such a campaign as you have successfully carried on." There is plenty of evidence to show that the advertising quack doctors, whether they conduct this business as individuals or as "institutes," are "on the anxious seat," and there is

also evidence to show that the work already done has checked the flow of gold into the coffers of these frauds.—Editorials *Journal A. M. A.*, Dec.

CHRISTIAN SCIENCE VS. NEW THOUGHT.

In replying to a letter received from H. Cornell Wilson, the Editor of *Critic and Guide* says: We believe in hearing the other side and therefore give space to the communication of our correspondent, whose sincerity we do not question. But has he proved anything? Has he even said anything? Nothing, except to assert that Christian Scientists are not new thoughters and *vice versa*. Perhaps not, as far as the name is concerned. In essence they are all the same. They all kneel at the shrine of ignorance and prejudice and fatten on the credulity and gullibility of the people. Anybody who asserts that he can cure deafness, or cancer, or aneurism, by absent treatment, by "thinking" or by prayer, is an ignoramus, a fakir, a buffoon or simply a downright fraud. No matter whether he calls himself a Newthoughter, an Eddyite, a Willmansite, a Weltmerite, a Dowieite, or whatsoever the name of the particular fakir patron saint may happen to be.

Current Medical Literature Items.

Healing of Suppurative Appendicitis with Calcification—Two cases are reported by Drs. C. J. Rowan and H. G. Wells, of Chicago. In the case of the first patient, who died of peritonitis and chronic nephritis, the condition was discovered at the autopsy. Apparently at some previous time this individual had suffered from an appendicitis, with formation of an abscess. This abscess had ruptured into the ileum and discharged the greater part of its contents into the bowel; the wall of the abscess, or at least the lower part of it, had then undergone calcification. Because of its location, and the fact that there were no adhesions to the surrounding surfaces, no trouble had resulted from either the calcified mass or the adhesions. The second patient was operated on for intestinal obstruction probably due to a band of adhesions resulting from a previous attack of appendicitis. At the place of adhesion could be felt a strong, hard disc which seemed to be incorporated in the wall of the bowel. On attempting to cut through the hard disc which formed the adhesion of the bowel, it was found to be calcified. The disc was left in the wall of the proximal end of the loop, as its removal would have left a large defect in the wall of an already contracted intestine, the repair of which would have left a serious degree of stenosis. The patient died 26 hours after the operation.—*Journal A. M. A.*

Acute Abdominal Pain—Dr. C. M. H. Howell, in *The Practitioner*, London, October issue, says: In all cases in which the onset has been very severe the patient should be kept under close observation, and the following points relied on for making a diagnosis and at the same time indicating immediate operative treatment: (1) Increasing rapidity with diminution of volume of the pulse, especially if associated with a falling temperature. (2) Any indication of free gas or fluid in the abdomen. (3) Diminishing movements of the abdomen during respiration. (4) Gradual concentration of pain and tender-

ness at one particular spot in the abdomen, corresponding to the site of the lesion and gradual diffusion again from this spot as general peritonitis sets in. Cases, however, will occur, he says, in which, after the most careful consideration, it is impossible to make a certain diagnosis. In these, should the collective evidence point to the probability of rupture, an exploratory operation should be performed at once, lest delay, which hourly lessens the patient's chance of recovery, should cost him his life.

Appendicitis in Babies—Kirmission and Guimbellot (*Revue de Chir.* No. 10, 1906), state that the occurrence of a case of appendicitis in a child of eleven months of age led them to look up the literature of the subject and, as a result, they report twenty-six cases. Nine were in the first year and seventeen in the second and nineteen of the whole number died. They consider that this disease is not so rare at this time of life as has been supposed. It develops rapidly and the outlook is exceedingly grave. The only cures which have been reported are those in which an operation was performed in the acute stage without delay. The usual reason for not operating promptly is that it is exceedingly difficult to make a positive diagnosis.

A Case of an Infant Menstruating from date of Birth.—The first child of healthy white parents was born at their country home, in Wythe County, July 14, 1905. On the 18th of the same month I was called to see the child, and found undoubted menstruation. Its breasts were enlarged, congested and tender and a milky fluid oozed from the nipples. The menstrual flow continued for three days, and at the end of that time the congestion left the breasts, but they have remained unusually developed. The flow has reappeared each month with no perceptible effect upon the child; she appears normal and healthy in all other respects.

I find two kindred cases mentioned in Vol. I of *Medical and Surgical Gynecology*, Pozzi, as follows: "Campbell has recorded an excessive development of the generative organs in a child of four years who had regularly menstruated every three weeks since birth." Prochownik had the opportunity of performing an autopsy upon a little girl of three years who had begun to menstruate at one year, and found upon the ovaries all the signs of both old and recent ovulation.—*Dr. Ribble, in the Virginia Medical Monthly*

The Action of the Salicylates in Rheumatism.—R. Stockman notes that in the absence of any certain knowledge regarding the specific microbe of acute rheumatism and its toxins, it is impossible to determine experimentally whether the salicylates act as bactericides or as antitoxins. Their action on known organisms and ferments is one of inhibition of action of both living ferments and enzymes. In the body their action is conceivably exerted in either direction. Their effect in acute rheumatism is definite and certain. With reference to the characteristic shifting of the pain from joint to joint, and the rapid subsidence of the latter from an inflammatory state without permanent damage, the author says that we should not regard this shifting as a metastasis. The fact rather signifies that all the joints are not invaded simultaneously by the

morbific agent. The most probable explanation of the rapid subsidence of the swelling and pain is that locally in the joint an antitoxic or antibacterial substance is formed which powerfully antagonizes the poisonous agent, and does it so rapidly that the joints are very seldom injured. The closed cavity of the joint probably favors the accumulation of the antibody until it reaches a highly active degree of concentration. This view is supported by the circumstance that, while the fibrous tissues of the joints, tendons, and aponeuroses are also very often the seat of rheumatic infection, it is well recognized that in these places the inflammation is usually very persistent, and apt to leave behind permanent fibrous thickenings. This, says the author, is owing to the antibody being in much less quantity in the body serum than in the joint effusion. The explanation of the rapid action of sodium salicylate on the pain and swelling of the joints is that it is excreted into the joint-cavity from the blood in comparatively large amount, as can be readily shown by its detection in the fluid withdrawn by means of a hypodermic syringe. On the other hand, colonies of microbes settled deep in the fibrous tissues, or in the valves of the heart, are more or less sheltered from the action of the salicylate, and are probably scarcely reached by it; or, if reached, the solution in the serum is too diluted to exert much action. This is suggested as the explanation why valvular rheumatic affections and those of fibrous tissues generally are not nearly so amenable to the action of salicylates as the joints are. The important practical deduction to be drawn from this is to treat the patient at once and with large doses, so as to kill off the microbes while they are still in the blood stream or joints, and before they have had time to establish themselves in the fibrous tissues. Early treatment with sufficient doses greatly lessens the risk of acquiring valvular disease and chronic fibrositis.—*British Med. Journal*, Nov. 24, '06.

Treatment of Herpes Zoster.—Ingelnans formulates the following treatment for zona: In simple herpes zoster the patient is to be given a purgative, followed by intestinal antiseptics, such as benzonaphthol or phenyl salicylate. He is kept upon a milk diet. To relieve the neuralgic pain he takes a pill of quinine sulphate (0.25 gramme or gr. iv) and extract of opium (0.01 gramme or gr. 1-6) as required. Or, he may take fifteen to twenty drops of the tincture of gelsemium during the day. The following ointment may be applied to the lesions: Cerate, 20.0 grammes; olive oil, 40.0 grammes; extract of belladonna, 0.06 gramme. Hemlock plaster containing four per cent. of powdered opium may be substituted. If the ulcerations spread and become gangrenous, antiseptic absorbent powders or dressings are substituted, such as charcoal or cinchona, with iodoform of phenyl salicylate. If the pains are severe, hypodermic injections of morphine may be given, or the actual cautery may be applied at the point of emergence of the perforating nerves. Fowler's solution may be given in increasing doses for the neuralgia. In ophthalmic zona, antiseptic solutions are used for the eyes, followed by an ointment of boric acid and zinc oxide (of each 2.0 grammes), or thymol iodide (1.15 grammes), cocaine (0.26 gramme), in petrolatum (20.0 grammes).—*Journal de Médecine*, September, 1906.

Deaths.

Pursell—At Whitehouse, Hunterdon County, N. J., after a brief illness from apoplexy, Dr. William W. Pursell, aged fifty-seven years. Dr. Pursell graduated at Jefferson Medical College, Philadelphia, in 1874; served a short time as resident house physician in the Bedford Street Hospital, Philadelphia, and subsequently settled in Hunterdon County and practiced medicine in Whitehouse and vicinity for thirty-two years.

Van Syckle—In Clinton, N. J., December 7, Dr. Sylvester Van Syckle, aged eighty-one years. He was born in Union township, Hunterdon County, educated in the schools of Easton, Pa., and at Princeton College. Graduated in medicine at the New York University in 1849, served in Bellevue Hospital as an interne two years, after which he settled in Clinton, where he continued to practice medicine until a few days before his death, which was caused by pleuro-pneumonia.

Monthly statement—Board of Health of the State of New Jersey, November, 1906. D. S. South, Registrar.

The number of deaths reported to the Bureau of Vital Statistics for the month of November, 1906, was 2,463. Pneumonia and diseases of the respiratory system show a high death rate. Diseases of the nervous system show a slight decrease, but still constitute the leading cause of death. The mortality from typhoid fever shows a decided increase, which is usual at this season of the year. The number of deaths from this affection for the past five months have been as follows: July 24, August 28, September 20, October 27 and November 53. Pulmonary tuberculosis caused 234 deaths during November, which is the lowest figure for the past five months. By ages there were 545 deaths among infants under one year, 105 deaths of children over one year and under five years, and 609 deaths of persons aged sixty years and over.

The following table shows the number of certificates of death received in the State Bureau of

Vital Statistics during the month of November, 1906, and also the number of deaths from certain selected causes.

Causes of death and number of certificates received: Typhoid fever, 53; measles, 3; scarlet fever, 9; whooping cough, 13; diphtheria and croup, 60; malarial fever, 0; tuberculosis of lungs, 234; tuberculosis of other organs, 39; cancer, 112; cerebro spinal meningitis, 16; diseases of nervous system, 306; diseases of circulatory system, 227; diseases of respiratory system (pneumonia excepted), 144; pneumonia, 159; infantile diarrhoea, 161; diseases of digestive system (infantile diarrhoea excepted), 154; Bright's disease, 147; suicide, 21; all other causes, 605; total, 2,463.

Food and Drugs—During the month of November 1906, 342 specimens were examined under the direction of the State Board of Health, in the State Laboratory of Hygiene, as follows:

	No. of Specimens	No. above Stand-ard.	No. below Stand-ard.	Per Cent. of Spec'm's Adulter-ated.
Milk,	203	147	58	27.5
Butter,	5	5	0	0.0
Cream,	16	14	2	12.5
Honey,	3	3	0	0.0
Molasses,	19	18	1	5.2
Molasses, compound,	1	1	0	0.0
Oleomargarine,	3	3	0	0.0
Olive Oil,	5	4	1	20.0
Sausage,	1	1	0	0.0
Syrup,	2	2	0	0.0
Vinegar,	1	0	1	100.0
Vinegar, cider,	30	19	11	36.6
Vinegar, white,	1	1	0	0.0
Camphorated Oil,	5	4	1	20.0
Tincture Aconite,	1	0	1	100.0
Tincture Iodine,	13	0	13	100.0
Tincture Opium,	9	1	8	88.8
Totals	318	223	95	29.8

Number of samples of water analyzed, 24.

Bacteriological Examinations for Diagnosis

—During the month of November 792 specimens were examined for diagnosis as follows: From suspected cases of diphtheria, 338; tuberculosis, 249; typhoid fever, 181; malaria, 12; miscellaneous, 12.

Believing that the matter of the medical examiners' fees affects the welfare of life insurance policyholders, and the rightful claims of the medical profession, it is suggested that the local and county medical societies which hold meetings between this date and January 25 pass a resolution requesting the President of the Medical Society of New Jersey to appoint a committee of five, who shall prepare and issue a statement to the public on this question.

Dec. 1, 1906.

THE EDITOR AND PUBLICATION COMMITTEE.

The JOURNAL will be glad to print original papers from any source, preferably from members of the State Society, provided that they shall be of sufficient merit and shall be contributed to this paper exclusively.

Anonymous communications will not be published, but the name of the author of a communication will be kept secret if the editor is requested to do so.

The Medical Society of New Jersey does not hold itself responsible for the sentiments expressed by the authors of papers.

It will be satisfactory to all concerned if authors will have their contributions typewritten before submitting them for publication. The expense is small to the author—the satisfaction is great to the editor and printer. We cannot promise to return unused manuscript.

Authors may obtain reprints of their papers at cost, provided a request for them be written on the manuscript.

Matter received after the 20th of any month cannot appear in the next issue of the JOURNAL.

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HYSTERIA AND NEURASTHENIA IN WOMEN*.

By Martin J. Synnott, A. M., M. D.,
Montclair, N. J.

In selecting this subject, the writer does so with no intention of intruding upon the domain of the nerve specialist. Hysteria and neurasthenia are diseases of frequent occurrence, and while the alienist may perhaps be called occasionally to confirm the diagnosis, in the vast majority of cases the treatment is left in the hands of the family physician. It follows, therefore, that the general practitioner sees a greater number of patients, and is in a position to watch the course of the disease and to study it more carefully than the specialist.

We have grouped hysteria and neurasthenia under one head in this paper, because while they are regarded by most writers as separate and distinct maladies, they are so nearly alike in etiology, general symptomatology, prognosis and treatment, that what is said of one is almost equally applicable to the other. Hysteria seems only a more aggravated form of neurasthenia, plus the so-called stigmata by which the former is recognized, *e. g.*, hemi-anaesthesia, anaesthesia, paralysis, contractures, or convulsions. Just what pathological process is at work in these diseases is as yet unknown and an accurate definition is therefore difficult to formulate, but we are safe in the conjecture that the same disturbances of the central nervous system underlie the phenomena of neurasthenia, hystero-neuras-

thenia and hysteria, and shade off by almost imperceptible gradations into acute mania. The most we can claim is the satisfaction of feeling that our knowledge of the subject has at least progressed beyond the stage of assuming that all hysterical patients are shamming or malingering, and that they could control their symptoms by an effort of the will if they chose to do so. On the contrary we now recognize a distinct group of symptoms, constituting a disease of positive form with mental and emotional characteristics of a more or less definite type. The literature on these diseases is very vast and it is difficult for a writer on the subject to keep within moderate limits. I shall therefore endeavor to omit theory and didactic teaching as much as possible and to clothe and elaborate the framework of the subject mainly with observations from my own clinical experience.

ETIOLOGY.

In the etiology of probably no other disease does hereditary predisposition appear so important a factor as in hysteria and neurasthenia. In the majority of cases we can readily trace the influence of heredity in the family history. We often see the neuropathic taint extending through a whole family. Thus I have in mind a family of five adult brothers and sisters, all in good health physically, two of whom show marked neurasthenic symptoms; one suffers from melancholia, another is a cocaine habitue and the fifth is of a highly organized nervous temperament with many eccentricities. The father of this family had a paraplegia for many years and died from senile dementia. A family history of epilepsy, convulsions, asthma, chorea, insanity, syphilis, or some other nervous dis-

*Read before the Medical Society of New Jersey at its 140th annual meeting, Atlantic City, June 21st, 1906.

ease, is frequently found in our hysterical patients. Alcoholism or tuberculosis in the parents often results in a neurotic condition in the children. Early education and environment are important factors in the etiology of these diseases. A neurasthenic mother cannot but have a baneful influence over her children. They live in an atmosphere of nervous tension and are either entirely neglected by the mother, who is too busy thinking about her own trivial ailments to pay much attention to her offspring, or else they are objects of extreme concern to her. In the latter case the poor children soon lose the buoyancy of youth and maternal conversation seems to them to have for its vocabulary the single word "Don't." Such imperfect early training creates a lack of moral responsibility and self-control. Overstudy combined with poor food and insufficient exercise may cause hysterical conditions, especially in children who are affected by an hereditary taint.

Many other factors enter into the etiology of these diseases. Neurasthenia seems to be a product of modern civilization and has been called by some "The Great American Disease." We go to extremes in all our acts whether it be the search for wealth, the ambition for fame, or desire for professional attainments. Even in our pleasures we show the same restless intensity; we violate all the rules of hygiene, nature's balance between the storing and expenditure of energy is upset, with the result that tired nerves sooner or later manifest themselves and exhaustion results. The simple life has been superseded by the strenuous life. So much so does this condition of affairs exist that functional nervous diseases make up today the bulk of the busy general physician's practice. Among women particularly other factors at work in the causation of hysteria and neurasthenia are domestic worries, unhappy love affairs and marriages, too-frequent child-bearing, overwork, diseases causing malnutrition and lowered vitality, accidents and pelvic diseases. The demands of modern society—women's clubs, bridge whist parties, gambling, tea drinking, may all act as exciting agents. Sexual perversion and inversion, masturbation and other forms of secret vice are habits often acquired by girls at very tender ages. Many fashionable female boarding schools are hot-beds of vice of this type. Such instincts and habits with the mental and moral perversion, and the loss of self-control they entail, lead surely and inevitably to functional

disorders of the nervous system. Married women frequently invite these ailments by their fear of maternity. The wife who dreads maternity because of ill-health, poverty or bodily deformity deserves some consideration and pity; but the perverted society woman whose objection to offspring is based only on selfish motives can certainly find no excuse for the race suicide so much in vogue. The various measures in use among married women to prevent conception are oftentimes harmful and always morally deleterious. Coitus reservatus is particularly injurious to the wife whose sexual appetite is normally developed, and all practices of this kind, along with excessive sexual indulgence, may be factors in the etiology of hysteria and neurasthenia. The possibility of secret drinking and cigarette smoking even among women of education and refinement must not be lost sight of.

PATHOLOGY.

Hysteria and neurasthenia are functional nervous derangements and no organic lesion is present. The only possible exception is the condition known as traumatic hysteria and neurasthenia, a condition which Erichsen and many others have described under the name of "railway spine" and "railway brain" to superficial lesions of the cord and meninges. It is not improbable that in traumatic neuroses there may be some slight anatomical lesion, blood extravasations, bruising or minute ecchymoses, as pointed out by Clarke and others, which are of interest as regards the mode of production of these disorders.

SYMPTOMS.

Convulsions and fits are frequently met with in the more pronounced cases of hysteria. They are sometimes mistaken for epileptic seizures. The aura is present, but is more elaborate and prolonged than in epilepsy. It is usually one of "globus hysteria" or "clavus" (pressure at one spot on head). The hysterical attack usually comes after some emotional excitement. The patient seldom injures herself if she falls, never bites her tongue, as in epilepsy; she cries and screams during the fit and, as the attack subsides, she may expel flatus or pass a large amount of limpid urine, but the urine and faeces are seldom passed involuntarily. These convulsions of hysteria, unlike epileptic seizures, never occur in sleep. In this connection I can recall an interesting case occurring in my practice, of a young girl who had several attacks of this

kind, and I diagnosed her trouble as hysteria. All the clinical symptoms seemed to be present and the case quite characteristic until I was called one night to her home and told by the excited household the following history: She had gone to bed in good spirits and health. During the night her sister, who slept in an adjoining room, was awakened by unusual sounds, and found her in a fit. It was quite typical of epilepsy and was followed by a deep sleep which lasted until morning. When she finally awakened she had no recollection of the fit and no knowledge of any unusual occurrence during the night. She complained only of a feeling of confusion and some stiffness of her jaws. The subsequent history of this case convinced me that my original diagnosis was wrong and that she had not hysteria, but epilepsy. Attacks of hysterical sleep or trance, and catalepsy are interesting phenomena of hysteria and are occasionally met with. Somnambulism, noctambulism and somniatio may complicate hysteria, but are rather rare paroxysmal manifestations. Conditions of this kind with highly developed states of double consciousness were probably known to Robert Louis Stevenson when he wrote the story of "Dr. Jekyll and Mr. Hyde." Catalepsy may follow a convulsion, in which case the various attitudes assumed by the patient are probably the accompaniment of hallucinations. Or it may occur as the chief symptom or be induced by hypnotism. At one of the principal theatres of New York City I recently saw an interesting demonstration of a cataleptic condition brought about in this way. A young French woman, while in an hypnotic trance, was seated in a statue-like attitude with the arms extended at right angles to her body. Such was the rigidity of her whole muscular system that weights so heavy as to require the united strength of two men to lift were suspended from each wrist and held there without a tremor for several minutes.

A few weeks ago I was called to see a young Italian girl whose friends were greatly concerned because she had suddenly fallen into a state of unconsciousness from which they could not arouse her. This state had followed an hysterical crying spell, the result of a mild whipping administered by the mother as punishment for some slight offense. She remained in this state for several hours, and awakened from it finally in her normal health and spirits. During cataleptic attacks of this kind the pulse and respiration are not affected, a point which is

often an aid to the physician in diagnosing the condition. Paralyses, aphonia, joint contractures which usually disappear during sleep and chloroform narcosis are not infrequent symptoms of hysteria. Hysterical paralyses follow, according to their distribution, one of three forms; (1) monoplegic; (2) paraplegic; (3) hemiplegic. Hyperaesthesia, especially of the spine, breasts, abdomen and ovarian regions, the "clavus hystericus," irregular areas of anaesthesia, contraction of the visual field and other disturbances of vision, loss of the senses of taste, smell and hearing, are among the more common sensory symptoms. Occasionally the senses are more keen. Thus I have in mind a patient who, when in bed, with her room door closed, is able to hear a whisper in distant parts of the house. My own observations in this case have been verified by those of the husband and nurse. The "globus hystericus," vomiting, depraved appetite, reversed peristalsis, spurious haemoptysis, cough, tachypnoea, stammering, rapid pulse, slow pulse, circumscribed oedema and skin affections are some of the many digestive, respiratory and circulatory disorders due to hysteria. Pseudo-angina pectoris is a disturbance occasionally met with in both hysteria and neurasthenia and often puts the diagnostic ability of the physician to a severe test, especially if a murmur is present. The patient usually appears very sick, the pulse is rapid and weak, vasomotor disturbances are present, the body cold, face anxious, or ashen gray. The attacks are frequently nocturnal. There may be a dyspnoea and inability to lie down. They are accompanied by a feeling of syncope and extreme weakness but the patient never loses consciousness. The attacks usually occur very close, and in this they differ from true angina. The pain rarely radiates down the left arm unless this symptom is suggested to the patient by nurse or doctor. I once foolishly asked a young woman suffering from hysterical angina if the pain extended into the arm and she answered in the negative. When the next attack came I had hardly entered the room when the patient exclaimed, almost gleefully, "Doctor, I have that pain in my arm you asked me about yesterday." The attacks are harder to relieve and last longer than attacks of true angina. In doubtful cases we must look for other evidences of hysteria or neurasthenia but often time only enables us to settle the diagnosis. Patients of this type usually select young unmarried physicians who have plenty of time to devote to them. They

enjoy sympathy and crave attention. The more concern and alarm they can arouse among relatives and friends, the keener their pleasure and the oftener their attacks of pain. They like to "play to the galleries," but when the audience ceases to applaud and the physician gets tired answering hurry calls they usually recover.

Urinary symptoms are very common. Frequent micturition with the voiding of large quantities of limpid fluid of low specific gravity is very common. Retention is often seen, but incontinence is unknown. Anuria is occasionally seen, in which case the sweat, vomit and other discharges are loaded with urea, but in this condition, like hysterical constipation, we must be on the lookout for deception. In this connection I recall the case of a young married woman of a decidedly neurasthenic type who, several days after the operation of curettage, announced to the nurse that she could no longer urinate. A few hours before this time, during my regular visit, the nurse had remarked to me that the patient did not void very often, and I had in reply cautioned her not to hold her urine too long. This was all the suggestion necessary and the patient caught her cue. For several days I had to visit her three or four times each twenty-four hours to pass the catheter. She claimed that the process was extremely painful to her and resisted so violently that the nurse was unable to accomplish it unaided. Cocainizing the meatus was necessary. I quickly suspected that she was shamming and gave orders that the catheterizing was to be done only once in twenty-four hours and then by the nurse, otherwise she must suffer the discomfort of a full bladder until she could bring herself to submit. At the end of the first day the nurse found only four ounces of normal urine. This fact convinced us that the patient was deceiving us and could void normally. It was found, as a result of careful watching, that while the nurse was absent from the room she would use a drinking glass for a urinal and empty it from her bedroom window. We at once gave up the catheter, never mentioned the subject to the patient again and had no further trouble from this source. Painful micturition, without any bladder condition to account for it, is another symptom occasionally met with. Such patients apparently suffer excruciating pain when they have occasion to perform this act and live in a state of dread from one urination until the next. This condition rapidly disappears if the mind can be di-

verted by a change, as by travel, especially an ocean voyage.

Craving for sympathy and notice, increased irritability, depression, melancholia, deception of all kinds, self-injury, criminal acts, untruthfulness, impaired mental capacity for work, poor memory, tinnitus aurium and morbid fears of people and places may appear severally or alone in our neurasthenic and hysterical patients. Of the various forms of morbid fears and uncontrollable thoughts which are so often a distressing feature of these diseases, one of the most common and characteristic is claustrophobia—the fear of being shut up in a closed room, the fear of travel, of going through a tunnel, or the subway, or into any large assemblage of people. I have a patient in whom this symptom is very pronounced. She finds it difficult to attend the theatre or church and when she does always sits as near the door as she can get, is constantly on the alert and ready to leave at any moment. When traveling she will never remain in a locked room or compartment and on a steamer must sleep with her stateroom door ajar, preferring the risk of being seen *en deshable*, although a very modest woman, to the disagreeable consciousness of being in a closed room. Another form is agoraphobia, in which the patient cannot cross an open space alone, but must either walk immediately behind another person or hold someone's hand. Then we have the fear of sudden death, or some vague dread of heart disease, and lack of confidence and uncertainty in one's self, as when a woman will arise from bed two or three times to see if she has really turned off the gas or locked her room door. Sensations in the head are more frequent in neurasthenia than in hysteria. We meet with all degrees of pain and discomfort; the "casque neurasthenique" of Charcot, intense hyperaesthesia of scalp, where the patient cannot use comb or brush, numbness, fullness, sensation of having a "wooden brain," dizziness, confusion and vertigo. Insomnia is often present and is a serious complication; where it does not exist, the prognosis is much more favorable.

PROGNOSIS.

These diseases are never fatal in themselves and the prognosis is usually good, although the pronounced forms of hysteria and hystero-neurasthenia sometimes, as already pointed out, lead on into attacks of acute mania and other types of insanity from which recovery may not take

place. In a given case, aside from the severity of the symptoms, much depends upon the environment, the treatment and nursing, and the moral force of the patient.

TREATMENT.

First of all in the treatment of these diseases it is important to positively exclude organic disease. This can usually be done after a thorough and exhaustive initial physical examination. In a severe case no clinical resource should be neglected, but urine, blood, faeces, etc., should receive in turn our attention. This plan inspires confidence in the patient and excludes the possibility of errors in diagnosis on our part. It is disconcerting, to say the least, to treat a patient for weeks or months for neurasthenia with cerebral symptoms and then have a brother practitioner correctly diagnose the case as one of cerebral tumor or syphilis. Preventive treatment gives excellent results in these diseases. Children, who are known to have a neurotic family history, should receive careful attention in their youth. Teachers should be instructed to show them special consideration, they should not be pushed too fast in their studies, their diet and exercise should be carefully regulated. Tea and coffee should be absolutely forbidden. This applies also to children who are weak physically either as the result of disease, accident or birth. Such children should not be permitted to go into competitive contests of any kind, should not be required to study for, or worry about, examinations and the best schools and teachers should be selected for them. The morals of such children should be most carefully guarded and their native innocence protected in every way possible. They are easily vitiated by bad companions and quickly learn bad habits such as masturbation. Parents and guardians of such little ones have a great responsibility and they must be impressed with it. Our modern methods of education are far from perfect, but, with our medical school inspectors and sanitary buildings, we are making progress in the right direction. I believe the hours of school work, as at present in vogue, are too many both for teacher and pupil and the list of studies too long. Many subjects included nowadays in the up-to-date high school curriculum were better left for college electives. The modern educational ideal should be "*Mens sana in sano corpore*." To acquire and preserve a healthy body, the young student must be taught to be methodical and regular in his habits, learn mental

concentration, and good methods of study and allow sufficient time for exercise, sleep and diversion. The body cells are said to require twice as much rest as work and Kant's rule—eight hours for work, eight for pleasure, and eight for sleep would apply to children equally well as to adults if the working portion were considerably abbreviated.

We should always be on the lookout for, and be prepared to take active measures of prevention against, secondary neurasthenia complicating or following diseases of an organic nature, auto-infection as a result of indigestion, the infectious diseases such as grip, malaria and typhoid, over-indulgence in alcohol, tobacco, tea and coffee or drug habits. Women or girls who show neurasthenic tendencies should be carefully watched, and made to live normally as regards diet, exercise and rest. There are many women with decidedly neurasthenic temperaments who, as it were, are living continually on the "ragged edge" of an attack, and yet who are up and around performing their daily duties or avocations with a fair degree of success. Such women, with moderate care and an occasional rest or pleasure trip, may never actually break down or be compelled to go to bed. These are the patients who consult us at our offices for cerebral, spinal, or gastrointestinal disorders. Many of them present no more marked symptoms than the morbid fears already referred to, such as claustrophobia and agoraphobia. Happy and fortunate indeed is such a woman if she possesses a husband and family who can understand and make allowances for her condition. If she can be spared worry, overwork, the cares of a too-frequent maternity, given plenty of recreation, travel or change and taught to live a healthy moral and physical existence, she will recover; otherwise the future has nothing in store except misery for her and for those with whom she is thrown in contact. Where a direct cause for our neurasthenic symptoms is discovered by our physical examination, it should, of course, be removed at once. A torn cervix or perineum should be repaired, a rectocele or cystocele, or uterine prolapse should be operated on as soon as practicable, and a retroverted uterus causing dysmenorrhoea should have appropriate treatment. An operation when performed should be carefully timed, to get the greatest possible psychological and moral effect. The "*sine qua non*" of success is to gain the patient's confidence and to impress her with the be-

lief that we understand her case thoroughly. We must appear interested and listen carefully each day to the enumeration of symptoms new and old. Our speech should be guarded, the less said the better. Too much sympathy should not be given the patient, but we can accomplish something by the assurance firmly given that the symptoms which seem so grave and realistic to her, are not so grave as they seem and need occasion no great concern. She should be urged to exert self-control and taught the importance of co-operating with the physician and nurse. Rest in bed and absolute isolation from visitors and other members of the family for a time is occasionally necessary in severe cases. The treatment should be systematic and varied as possible, including electricity, hydrotherapy, vibratory massage, passive exercises, resistance movements, Neuheim baths, mental therapeutics and suggestion, in order to keep the patient interested and to convince her we are resorting to every expedient in our armamentarium in order to bring about her recovery. We must take care, however, to impress her with the belief that we are working scientifically and with definite aim, otherwise she will get the impression that we are trying experiments with her, and then all further efforts will prove futile.

The co-operation of the patient's husband and family is necessary of course. Some of our measures may be disagreeable to the patient and then firmness is required. A good nurse is a great help, although it is difficult to find one who can successfully handle a case of this kind. She requires special characteristics: good judgment, the patience of Job, kindness at all times, and she must understand the judicious use of severe measures when expedient. If the home surroundings are at the bottom of the trouble it may be wise to send the patient away to a sanatorium or a health resort in order to furnish her with cheerful diversion. Health establishments are not to be advised however, except under special conditions and for a short time only, for, as Dr. Dana has well said, these places are apt to contain too many patients of the same kind, who discuss their ailments one with another and by such discussions tend to accentuate and perpetuate them. A long sea voyage in a comfortable ship with good wholesome food is the ideal way of procuring rest and recreation. The enforced rest and seclusion, the absence of news from the outside world, the almost forced feeding accompanying an increased appetite are all

favorable for the relief and cure of neurasthenia.

Drugs are usually necessary to relieve certain symptoms, but they should be selected carefully and used sparingly. The patient should never be told what she is taking or given the prescription. Preparations should be dispensed with blank labels so that renewals without our knowledge will be impossible. Morphine, chloral, bromide, cocaine, are better not given at all if it is possible to avoid doing so, because nervous patients crave medicines and drug habits are easily induced in them. When drug habits are once acquired they augment the lack of self-control already present, the mental and moral perversion becomes more pronounced, and many cases curable before have thus been made hopeless invalids and useless members of society by the physician, careless or imprudent with his prescribing. We may in this particular take a lesson from the homeopaths whose remedies possess at least the merit of being innocuous. Dyspepsia may need the use of the stomach tube and special remedies such as dilute acid or sodium bicarbonate with infusion of gentian. The heart symptoms may require arsenic, strophanthus or nux vomica: caffeine is contra-indicated if there is much restlessness or insomnia. For the latter symptom, hypnotics should if possible be avoided; other measures should certainly be tried first, such as the wet pack, hot bathing to the spine, or a light meal at bedtime. Bromide, sulphonal, trional, chloralamide or paraldehyde are the drugs most commonly used. Valerianate of zinc given as a tonic three times a day is said to be of use indirectly in promoting sleep. This same drug, given in pill form, with a small dose of quinine or iron, or in cases with intestinal discomfort and much flatulence combined with asafœtida, is recommended by Clarke as a valuable remedy in the treatment of neurasthenia. The glycerophosphates, the compound syrup of the hypophosphites, cannabis indica and sumbul are all useful remedies, in the treatment of nervous fatigue. The use of cacodylate of sodium subcutaneously has given good results in the hands of some physicians. Cases of neurasthenia accompanied by pain in the back and limbs are often benefited by a combination of ammonium bromide and salicylate of soda, each 10 grains, three times daily, combined with nux vomica. This should not be given for a long period lest it upset the digestion.

Neurasthenic patients should be well fed, and usually a mixed diet is best. Where

severe and frequent headaches occur, and other evidences of imperfect proteid metabolism exist, the proteids should be restricted. Alcohol, tea, coffee and tobacco are, of course, to be forbidden. The treatment of traumatic neurasthenia or hysteria, "railway spine" and "railway brain," requires special consideration. Such conditions are particularly amenable to suggestion. The physician must learn to recognize suitable cases for mental therapeutics and treat them when necessary along these lines. The nervous patient is naturally credulous and the mental condition resulting from the disease makes her an easy prey to Christian Scientists and various other unscientific, uneducated and dishonest leaders of cults. It is easily understood why osteopaths have such great success with this class of patients. The enthusiasm of a neurotic patient is easily aroused over any new treatment, and she is ready to receive the suggestion that a cause for her symptoms has been discovered and that she is to be promptly relieved. This in itself usually benefits and sometimes cures her. The educated and intelligent physician should recognize these facts and is fully justified in using this plan of treatment himself, calling it "hypnotism," "mental cure" or any other name he may select. The effects of litigation in cases of neurasthenia must also be considered. The fear of court proceedings, the cross-questioning of lawyers and the uncertainty involved in the outcome of legal cases, all tend to aggravate the patient's symptoms. Questions involving litigation, therefore, should be settled as promptly as possible.

At times all treatment is unsatisfactory, relapses are frequent and discouraging, and the best we can do is to treat the symptoms from day to day as they arise.

THE TREATMENT OF CHRONIC NERVOUS CONDITIONS.

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I am well aware that in choosing for my subject so broad a theme as the treatment of chronic nervous conditions, I am laying myself open to the charge of attempting to discuss the whole subject of therapeutics. For I am very sure that most of you have at one time or another, when attempting to

give relief to such cases, tried almost everything known in the pharmacopoeia, or out of it. But whether we know exactly what to do, or not, such cases are constantly presenting themselves in our practice and we should welcome all suggestions that enable us to make more comfortable the lot of these most wretched of all patients. For I know of no more miserable object than the man or woman who has passed into a chronic nervous state. Such a patient is not so dangerously ill as to need the daily watchful care of the general practitioner, neither are his nervous symptoms startling enough to keep alive the interest of the nerve specialist. If a woman, she has already been the rounds of the gynecologists with varying degrees of relief and has realized that they can do nothing more for her; and if a man, the chances are that surgery has long since done its utmost by removing a doubtful appendix. And so the poor creature comes into our hands in a truly pitiable condition of suffering and despair. It is such cases as these that tax our ingenuity and nearly wear our patience threadbare. But there are ways of helping them, and a few of these I propose to discuss with you to-day from a practical everyday standpoint.

In endeavoring to give relief to a chronic nervous case, it should be our first care to make a careful, independent diagnosis, irrespective of what the patient reports about himself. And even when such cases are sent with the diagnosis already certified to by a reputable physician, we may often avoid mistakes and save much time and trouble by overhauling the case in our own way. It has been the experience of all of us that familiarity with these chronic cases often breeds more or less impatience with their symptoms and tends to blunt our perception of small indications that might otherwise give us valuable hints for treatment. When seeing chronic nervous cases for the first time it is my custom to make a thorough physical examination including especially careful palpation of the spine and abdomen. The condition of the digestive, urinary and sexual organs should be ascertained and at the very outset all questions of eyestrain eliminated. I realize that this means much time and thought, but it pays in the end. Such an examination cannot properly be made in the routine of office practice, but should require a special appointment. Family history and present surroundings play an important role and financial problems are often at the bottom of much trouble. All these questions enter so largely into the

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ultimate result of our treatment that they should never be overlooked. Having gained a good general picture of our patient's condition, the question arises, can we cure the underlying cause, or can we only hope to ameliorate the symptoms. More often than not, the underlying cause is due to so complex a condition, that we must despair of effecting a cure, but it should be our aim in every case, while relieving symptoms, to be constantly endeavoring to reach the cause and cure it. Frequently no definite diagnosis can be made and we must content ourselves, however unwillingly, with simply treating our patient symptomatically. Were we restricted in such treatment to the use of drugs I do not see how we could hope to accomplish anything satisfactory; but it is just here that our modern methods of physiological therapy come in and put at our disposal means of giving relief to these chronic nervous conditions and in many instances eventually curing them.

I want right here to put myself on record as believing that, as scientific practitioners, we should be especially watchful never to cease looking for the underlying causes of these nervous conditions, even when we are driven by circumstances to treat only symptoms. If we are on the lookout we may at any moment stumble on the real cause of all the trouble and thereby save our patients weary months of waiting and ourselves untold anxiety.

Of the methods of treatment at our disposal we naturally think first of those found in our *Materia Medica*, but I am thankful to say that we are getting to rely less and less on drugs. The man who continues to treat nervous insomnia with trional or veronal; or chronic neuritis with salicylates and opium; or eczema and psoriasis of long standing with arsenic and iodides is not worthy the name of a scientific physician. Having realized the futility of obtaining definite results by relying solely on drugs, we are driven to add to them other measures. And the better we become acquainted with the action of hydro-therapy, and mechano-therapy and electricity, and the more carefully we study into climatology and balneology, the more firmly are we convinced that in the use of such measures will lie our ultimate success in the treatment of chronic nervous conditions. Please do not understand me as advocating the discarding of drugs. So far from that I believe thoroughly in their use under many conditions. But we are no longer tied down to medication and forced to give up trying to

relieve our patients when drugs fail to allay the symptoms. The sedatives, the hypnotics, the cathartics and the tonics should play just as important a role as ever in our consideration of the curative means at our disposal, but their use is decidedly modified by our knowledge of additional means, hitherto not so well understood or not deemed so important.

Of these means I wish to speak first of:

MENTAL SUGGESTION,

not as it is commonly understood under the head of hypnotism or mental healing or so-called Christian Science, but as the personal equation entering into the relation of physician to patient. Not all physicians possess the happy faculty of impressing on their nervous patients their own hopeful views of life, perhaps because many of them do not themselves look on the bright side. But it is my experience that with these cases firm, constant insistence on improvement, and a frequent rehearsal of all favorable signs and symptoms accomplish a great deal. Conservative suggestion of definite improvement at definite times, and the comparison week by week and month by month with the previous record, encourage the patient and teach him to expect progress. In no class of cases does the physician's personality play so important a part.

CLIMATE.

Probably every physician has at some time or another succumbed to the temptation of sending his chronic nervous patients away, with the excuse that a change of climate was necessary. This is a perfectly legitimate procedure if we have carefully considered the patient's tastes and means, and have chosen the proper climate. But too often our idea is simply to get rid of a troublesome case and shift the unpleasant responsibility onto other shoulders. Most chronic nervous patients are benefited by a change from time to time, but the choice of the proper surroundings and of the physician in whose care the patient shall be while away, should be a matter of careful and conscientious study. In general, I am strongly opposed to the large sanatoria for this class of cases for reasons that you will readily appreciate. The opportunities for comparing notes with many other chronic cases, the general lack of a carefully regulated individual regime, and in many instances the entire absence of any control over the patient's daily life whatever, have prejudiced me against them. In those cases needing institutional care the smaller rest cures and

private hospitals offer the best means for rapid recovery. But I am convinced that most of our chronic nervous invalids can be fully as well cared for individually rather than collectively. At home, or away from home, in hotels or boarding houses or summer camps, we can arrange a mode of daily life suitable to each patient. This means much thought in the selection of the particular place and a more complete knowledge of localities and climatic conditions than most of us possess. But it is well worth our while to acquire such knowledge, at the expense even of considerable time and correspondence. Some patients do best in a high dry climate, others improve more quickly at sea level, and again others make the greatest advance in the midst of city life at home. Whether it is best to send a patient away or not, must depend largely on his temperament, his pocketbook and the influence of his home surroundings on his symptoms. On these points I need not dwell, merely emphasizing the great importance of always keeping in mind the patient's financial status. I have very often realized, that the constant worry over the extra expense entailed by a prolonged absence from home did more to retard the patient's progress than all the means used improved it.

Having fixed on the proper place of abode, the next important step is what curative measures to adopt. Most so-called "resorts" offer some especial features in the way of treatment, such as the hydro-therapeutic appliances at the Hot Springs of Virginia or Arkansas; the mineral waters at Saratoga or Richfield Springs, or the opportunities for sea bathing at Atlantic City and other coast resorts. All well-equipped sanatoria, large or small, offer facilities for treatment by means of electricity, massage, mechano-therapy and light, so that we have but to decide on the treatment needed at any given place. It is, however, my earnest contention that the general practitioner can easily qualify himself to take care of the majority of these chronic nervous cases and treat them himself, thereby saving them the necessity of going away from home, earning the everlasting gratitude of the patients and their friends and incidentally receiving the compensation himself instead of turning it over to others.

The agents to be studied and which can be applied at home or in the physician's office are:

1. Hydro-therapy. The bath tub; the spray or shower; the sitz-bath; the hot or cold wet pack; and the artificial Nauheim

bath offer means of reaching a very large class of cases. To illustrate. In a case of insomnia the result of worrying over business matters or following general debility, a Scotch douche following immersion in a tub of water at 106°F. for ten minutes, will act as a sedative, giving refreshing sleep. Again, a nervous hysterical woman suffering from pain at the base of the brain, and with her muscles all twitching, will get the greatest relief after 4-6 minutes in an artificial Nauheim bath at a temperature of 100°F., followed by quick drying off and an hour's rest on her back. A study of the various simpler forms of hydro-therapy adapted for home use will prove most helpful. The use of the more complicated apparatus found in sanatoria and especially equipped institutions must be left to the physicians in charge, and the results obtained by them are most satisfactory.

2. Massage. When given conscientiously by skilled manipulators, under a physician's direction, who knows what he wants done for that particular patient, massage is one of our most useful means of treating chronic nervous patients. But I wish to emphasize the necessity of the physician's personal supervision. It is my invariable custom when prescribing massage to give personal directions to the operator and to visit the patient within an hour after the first treatment and note the results myself. Only thus can we be sure that our patients react well, and that massage really suits them.

3. Mechanical Vibration is steadily gaining ground as a most important therapeutic measure in all forms of nervous disease, and I have found it especially adapted to the chronic conditions we are discussing. It effectually relieves the pain of chronic neuritis, it quiets and soothes an irritated spine, and relieves the sensation of fullness at the base of the brain so often complained of. It seems to favorably affect the nutrition of the spinal sympathetic nerves, thereby reducing inflammatory processes and favoring a return to normal conditions. Mechanical vibration is not massage, neither is it osteopathy as some have claimed. Its results warrant careful study and constant use.

4. Electricity. While the older and better known electric modalities, the constant and interrupted currents, are still in use and are of more or less value, it is from the static breeze and spark, and more especially from the high frequency currents that we get our most satisfactory results in the treatment of chronic nervous conditions. By

the use of solenoids and vacuum electrodes of various forms we can apply these currents to all parts of the body without producing the unpleasant sensations commonly associated with "electric treatment." This is an especially important feature when dealing with high-strung neurotic women, who will assure you that "electricity makes them so nervous." Pains, muscular twitchings, insomnia, nervous dyspepsia and general malaise and debility are relieved and in many cases entirely done away with. The idea that all treatment by electric currents does good primarily through its psychic effect has been disproven. While we are still at a loss to explain why and how these high frequency currents relieve, the fact remains that our patients get well under their carefully regulated use. Much discredit is thrown on electro-therapeutics by men who, without a sufficient working knowledge of its principles or of the practical application of the various forms of currents used, have failed to obtain good results and have therefore condemned the whole subject. Careful study and observation of the methods already in use, coupled with tact in applying these methods to individual patients, will lead to gratifying and often surprising results.

5. Light. The use of light, both white and colored, is receiving much attention of late and I must not neglect to speak of it in the treatment of the conditions we have been considering. The open air sun bath has long been known to be of great value, and in Europe most climatic "cures" resort to it. In this country it is used, among other places, at Cromwell Hall, Cromwell, Conn., with the best of results. Mechanical ingenuity has now perfected apparatus by which we can use powerful reflectors with 200-500 C. P. lamps in office or private work. This concentrated light applied for shorter or longer periods to the spine or abdomen or pelvic region, as the case may require, gives results hitherto not attained in any other way. Sedative and curative effects follow the use of such applications and the results are obtained with but little inconvenience and no unpleasant sequelae.

The limits of this paper do not permit of my going into details regarding the uses of the foregoing physiologic-therapeutic remedies, or of quoting individual cases, but I may say that I have not mentioned anything that I am not making almost daily use of in my general practice, or that cannot with perfect ease be used in the routine treatment of patients at their homes or in

the physician's office. The results obtained by the use of these means are so lasting and the relief given so decided, that no general practitioner should fail to carefully investigate and systematically make use of them in his daily practice.

DISCUSSION.

G. H. Balleray, M. D., of Paterson. —Dr. Synnott is a man after my own heart. He has chosen a topic in which I have long been interested, one in which we should all be interested, whether as specialists or general practitioners, and his treatment of the subject is masterly. As regards hysteria, that has been gone over very thoroughly. In the olden days the uterus, it was thought, caused many nervous affections and moved from one part to another part of the body. The globus hystericus was thought to be due to the lodgment of the uterus in the throat. It was believed by Hippocrates that about 600 diseases were caused by the uterus. Regarding the pathology of hysteria there has been a decided change of opinion. The subject of neurasthenia is so vast that it cannot be considered in all its bearings in the short time allotted for this discussion, but a cursory review of some of its salient features may not be unprofitable.

Causes: The causes of neurasthenia in women are numerous: Gastro-intestinal disturbances interfering with metabolism and resulting in general malnutrition, frequently repeated pregnancies, prolonged lactation, prolonged or profuse menorrhagia or metrorrhagia, leucorrhoea, uterine displacements, diseases of the bladder and rectum may all act as causes. Emotional disturbances, such as grief, anxiety, etc., are frequent causes of nervous exhaustion. Insufficient and improper food and unsanitary habitations favor the development of the disease; and, lastly, conjugal onanism and other methods of preventing conception. Criminal abortion and faulty methods of dress are responsible for a large proportion of the cases met with in practice. Hereditary lack of stability of the nervous system is a predisposing cause in all cases. All the causes of neurasthenia above mentioned are sufficiently obvious with the exception of conjugal onanism and fashions in dress. That the former exerts a deleterious effect on the nervous system of women there can be no doubt, and that it is extensively practiced is known to all physicians of experience. Of all the methods in vogue to prevent conception it is the most injurious—it converts the sexual act into a pathological process by cheating nature of her just dues, and when the time of reckoning comes nature demands her own with usury. The scripture tells us that "fear is torment," and the average woman lives, apparently, in greater dread of pregnancy than she does of eternal damnation, for she certainly takes greater precautions against it. If, as we are told, "Perfect love casteth out fear," we should like to see a little of the unadulterated article incorporated in the act of sexual congress. Physicians should instruct their patients in regard to the injury to the nervous system resulting from this violation of nature's law.

Of the pernicious influence exerted by the fashionable abominations worn by women, there can be no doubt in the mind of any sensible man, but the ignorance and consequent indifference which

prevails in regard to the matter, in the profession as well as among the laity, would be disheartening if it were not for the consoling assurance, "Blessed are the poor in spirit." Many cases of neurasthenia in women are clearly traceable to the disturbance of function resulting from compression and displacement of various organs by tight corsets, tight skirt-bands, etc. Compression and displacement of the liver, movable kidney, gastropotosis, enteroptosis and displacements of the uterus are often the direct result of the wearing of these wretched contrivances, and the nervous irritation caused by these various abnormalities results in neurasthenia. Some maintain that movable kidney, *per se*, is a cause of neurasthenia, but they forget that the movable kidney and the neurasthenia are but a part of the general malnutrition. The kidney is movable because the patient is emaciated and the circumrenal fat has been absorbed, leaving the kidney suspended by its moorings only. If such patients regain their lost flesh the mobility of the kidney disappears at the same time that the neurasthenic symptoms improve. To perform nephrorrhaphy on those cases is nothing more nor less than surgical quackery. When these patients recover after nephrorrhaphy it is not in consequence of it, but in spite of it. When recovery occurs it is due to the confinement to bed after operation and the improvement in general nutrition by appropriate feeding—not to the sewing of the kidney in an abnormal position. In cases in which the patient does not gain flesh after the operation the result is a failure—the mobility of the kidney returns. This is what any person with common sense would expect it to do, but common sense is a commodity with which some people are not overburdened. We are told in Proverbs that, "A foolish son is the heaviness of his mother." What a load the maternal ancestor of some practitioners has to carry!

Treatment. The first step in the treatment of neurasthenia is to remove the cause if possible. Life in the open air with freedom from care and anxiety is essential. Proper regulation of the diet and exercise is important, and if insomnia exists it should be combated by appropriate measures. Cold baths in the morning or cold spray or shower, followed by friction and massage are useful. If any lesion of the generative organs exists it should receive proper surgical treatment, but unnecessary operations should be avoided. Unless absolutely necessary, the patient's attention should not be directed to her genital organs. When a neurasthenic woman has, or thinks she has, some uterine or ovarian trouble she becomes a hypochondriac and it is difficult to draw her mind out of her pelvis. The morale of the patient should be improved by inspiring hope and confidence. There is no other disease in which the physician himself, stripped of his armamentarium or paraphernalia, exerts so great an influence for good. He should be gentle, patient, hopeful, resolute, exact and exacting. He must insist that his orders be obeyed, but the patient must not be ruled with a rod of iron. In very bad cases the patient should be isolated from friends and relatives, and a good, sensible well-trained nurse is indispensable. If the practitioner be clever and understand human nature he can prove the very Balm of Gilead to his patient. He can make her faith in him so strong that it will tend to break the intensity of physical discomfort or even suffering, and remove

from her mind apprehensions of gloom and despondency; and when, after weeks or months of treatment, the glow of health returns to her cheeks, and, the demon of despair having been exorcised, her mind rests in peaceful confidence as regards the future, he can say to her in the language of the Great Physician, "Go thy way, thy faith hath made thee whole."

Dr. William M. Leszynsky, of New York.—All of the gentlemen have discussed this subject from the general practitioner's standpoint, and what has been said is quite true, so that there is very little left for criticism. The general practitioner from the very beginning, and in the majority of the cases, does not get the best results in the treatment of these patients, because he cannot control the influences which surround them. I am speaking of the patients with abundant means, not the poor patients or those of very moderate means. Unfortunately, a large percentage of these people are unable to meet the expense entailed for suitable treatment. This is one of the difficult problems we must contend with in New York City. We do not know where to place these patients. They are not insane enough to be committed and the general hospitals refuse to receive them. I hope this problem will soon be solved and that we will ultimately succeed in getting some philanthropist to supply funds to establish and endow an institution for the treatment of this class. In the treatment of patients with supposed hysteria or neurasthenia, it is of paramount importance to be certain of our diagnosis. I am frequently consulted by patients who have been treated for these affections, who presented clear evidence of organic nervous disease. I can recall four patients with brain tumor seen this winter, who had for a long time been treated as neurasthenics. Such an error need not be ascribed to ignorance on the part of the physician. It is usually due to carelessness resulting from a lack of interest in all forms of nervous disease. It often happens when a physician gets a "nervous case," he soon tires of it and shifts it to the neurologist, which is usually to the patient's advantage. Within recent years our views have changed regarding hysteria and neurasthenia. We do not see many patients with pronounced and classical hysteria, as they are not so common in this country.

Patients with various obsessions and morbid fears, or fixed ideas, cannot be classified into types by themselves. I agree with Dr. Schauffer that one of the objectionable places for these cases is a large sanatorium. There a large number of patients congregate and, despite the printed rules of the establishment, persist in talking of their ailments. Thus, such impressionable patients compare notes and develop symptoms accordingly. Besides, they do not receive the necessary individual attention. In these institutions I have frequently noted that one physician may receive in his office forty or fifty patients in one morning. The small sanatoria are more satisfactory. I can see no objection, but every advantage, in treating these patients and selected cases of acute insanity in a so-called private sanatorium. No patients of this class are sent away from my personal control and observation who can afford to be treated in New York City in the manner mentioned. It is always more satisfactory to isolate these patients from their family than to treat them at home. I am often asked what I consider the most

efficacious drugs in the treatment of such cases. It is a common experience to learn that they have been subjected to drug treatment almost exclusively. The most important elements—the moral management of the patient and judicious psychotherapy—seem to have been forgotten. I use few drugs.

This class of patients with obsessions and morbid fears, or fixed ideas, the insane and those who suffer from other disagreeable mental symptoms, should always be placed in charge of an experienced and reliable attendant. It is sometimes necessary to change nurses several times before we obtain one who proves congenial to the patient. The graduate trained nurse, without special experience with this type of patient, is usually unsuitable. As to the use of electricity, massage, sunlight, hydrotherapy, etc., all agree as to their utility. Much has been accomplished by exposure of the body to the sun, instead of the hot air bath. I have not the great faith in electricity that Dr. Schauffler has. Electricity in itself, like massage, physical culture, etc., is only one of the means at our disposal, to be used in the general plan of treatment which must be adapted to the individual case.

Dr. Elihu Britton Silvers, of Rahway.—I would like to offer a reward of \$100,000 to anyone who could cure hysteria, but I will hold the money myself. I think Christian Science is of great value in the treatment of these cases. The trouble is too much drugs and not enough good sense. Fifty-four years ago my preceptor thought that he knew a great deal more than I know today and, on one occasion, he said to me, "Diagnose that lady's case." I started to do so and I thought she had an attack of bronchitis and I felt proud of my diagnosis. The old lady began to laugh. It was a case of hysteria and I lived long enough to have it proven. I remember some years ago that a homeopathic doctor came to my office at midnight and said, "I have a woman who is dying; what shall I do?" Christian Science cured her. There is one thing you should never forget in dealing with such cases—don't make light of them to the patient. I have not forgotten what was said to me years ago: "My son, you made a mistake; you should not have said there is nothing the matter with you."

Dr. William H. Walling, of Atlantic City.—With regard to electricity, the great difficulty in its use seems to be that it is indiscriminately used; the cases are not selected. I have used the various modalities in the conditions under discussion, but it depends entirely upon the individual case which form should be applied. As a rule, the so-called static form works well, in some the galvanic current is decidedly preferable. With many patients the intense fear of the agent must first be overcome, and then the question of the particular method to be employed may be considered. Another very important point is this: Our assistants should be trained. I never allow an inexperienced nurse to give electrical treatments. I always give them myself. I thus learn the peculiar nature of each patient, and which modality will be the better. The only way to get the best results is by studying the cases individually, and in person. There seems to be a difference of opinion as to the use of vacuum tubes. If the X-ray tube is attached in the wrong direction, there will be no light, i. e., no X-ray light produced; it seems as if the machine was running in the reverse di-

rection. Again, in using the ordinary vacuum tubes, the better result is obtained by attaching the tube to the negative side of the machine, with the positive pole grounded.

Dr. T. Y. Sutphen, of Newark.—I think these cases of so-called neurasthenia should not be passed over lightly; many are extremely serious. Tinnitus aurium is a frequent symptom and is not benefited by treatment of the ear, but does improve with an improvement in the general health and mental cheerfulness. In my experience, this disease occurs more frequently in thin, sallow and nervous women, and especially about the menopause. Some exciting cause in their liver aggravates all the symptoms, tinnitus occurs with the rest, and they are on the verge of insanity. Unless judiciously cared for and encouraged they go from bad to worse. As these patients are frequently roving ones, it behooves each physician to study his case from his own viewpoint, regardless of any previous medical opinion by other men, and search for the exciting cause, for such almost surely exists.

Dr. Walter B. Johnson, of Paterson.—The discussion has referred to the ophthalmologists. Some need to go back twenty years when they were young and good looking. Others have inadvertently tried to impress upon us the dangers from the ears. Schauffler said that it was very important that eye strain should be attended to. I hope the general practitioner will not forget that. You are here to take advantage of every opportunity offered. We are like the office boy who was taken into a back room and told, "You must do all you can to retain these patients." He did so, locking the door so that the patients might not escape while he went for the physician. Gentlemen, we are in too serious a condition. Our session of this year is about to close and it is necessary that a certain amount of humor, enjoyment, sociality and pleasure should be injected into the meeting; we must wake up. I make these remarks for two reasons; first to impress upon the minds of all that they must, before doing anything else with their cases of neurasthenia, send them to the oculist who will examine and possibly find that the trouble has been induced by strain of the ocular muscles, and that they need no treatment but the application of glasses. The second reason is, to compliment my friend Chambers upon the fact that twenty years ago he presumed that he was good looking. Gentlemen, he is better looking now than he was twenty years ago. I am glad that he looks as young as twenty years ago, and that the ladies who are hysterical employ him to-day with the same joy and satisfaction that they did then.

I consider the papers of Dr. Synnott and Dr. Schauffler as being very excellent. They have been instructive to all of us. The remarks of Dr. Leszynsky, the eminent neurologist from the Greater City of New York, have been of value and we have enjoyed them very much.

Dr. M. J. Synnott, of Montclair.—I do not know of anything to add except to emphasize the fact that there is danger of the neurasthenic and hysterical patients falling into the hands of the Christian Scientists and Osteopaths. These cases seem to be benefited by the osteopathic treatment and herein lies the danger. They are told by them that the cause of the disease is discovered and that there is, for instance, some vertebra out of

place, etc. The patient's enthusiasm increases, which goes a long ways toward a cure. Physicians should always bear this in mind and, so far as they can, practice "suggestion," but in an honest way.

Where operation is advised, it should not be undertaken too quickly. An operation may not do any good and if unsuccessful it even increases the invalidism of the patient. When an operation is to be done the time for it should be carefully selected. It should be done when the patient is in the best physical condition and when she really believes that she is going to get well.

The question of treatment of these conditions among the poor is a complicated one. In the first place they cannot afford to have expensive treatment or a trained nurse; they cannot get the close attention that is necessary nor the required number of professional visits. Fortunately such cases are rare. These conditions occur much more often among the wealthier than among the poor—a wise provision of Providence. When they do come to us as a rule they are caused by overwork, improper food, too frequent child-bearing, ill-treatment or abuse from drunken husbands. These cases are apt to go from bad to worse and often lead to acute mania or some incurable form of insanity. They not infrequently develop a suicidal tendency.

I think the point about giving medicines has been sufficiently emphasized. Other measures are to be preferred, and the fewer drugs used the better for the physician and for the patient. The patient craves medicine, but the simplest remedies, if accompanied by vigorous and positive "suggestion" from the doctor, will often accomplish wonderful results.

Dr. W. G. Schauffler, of Lakewood.—The terms hysteria and neurasthenia do not cover all the cases we are called upon to treat as cases of chronic trouble, but they are two of the most important ones, and they cover a multitude of sins.

The question of individual treatment of cases is to my mind the most important. Every case should be treated by itself, studied by itself. Dr. Leczynsky differs from most neurologists in the personal care of his cases; most neurologists will turn a patient out with general directions which cannot be followed unless the patient is in a private sanatorium. These are the cases that should be watched constantly and the best individual efforts should be given to each one.

CHOREA.*

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Chorea, conceived of as a state of demoniacal possession on the one hand, and chorea considered among the functional neuroses on the other, constitutes a change in medical thought scarcely less radical than that of the last half dozen years which have witnessed the transfer of this condition from the realm

of the functional disorders to that of the infectious diseases. Some steps in this latter process are of interest. When chorea was regarded as a state of demoniacal possession, the whole body was supposed to be pervaded by an evil spirit. When later it was classed among the functional neuroses the central nervous system was credited with the lesion. With the recent advances in neurological physiology and pathology, the lesion is now placed in the cerebral hemispheres and the choreic movements are ascribed to irritation in the basal ganglia and the cerebral cortex.

In order to understand the muscular movements in chorea, we must make use of some of the more recent facts in brain physiology. At birth the pyramidal tracts are undeveloped, and it is not until the twelfth to the sixteenth month that they really become myelinated throughout from the brain to the periphery and capable of transmitting motor impulses. The movements observed in the infant at birth are, therefore, transmitted over other motor paths now known as the primitive motor tracts. They transmit throughout life certain coarser movements of the limbs of a more or less automatic character, such, for example, as those of running and walking. These tracts in the human subject are poorly developed in comparison with their development in the lower animals. They have nothing whatever to do with the finer purposeful movements of the hands and feet. These movements are transmitted over the pyramidal tracts which become myelinated and capable of transmitting impulses between the twelfth and sixteenth month of infant life, or when the child begins to walk. Now, the movements of chorea concern chiefly the finer movements of the extremities. There are twitchings of the forearms, involuntary flexion and extension of the fingers, grimaces, shrugging of the shoulders, etc. The gait, if affected, is of a halting, jerky character, and in some cases the movements of the tongue, the larynx and even of the pharynx, are seriously interfered with. These movements are, for the most part, transmitted over the great motor tracts from the brain to the periphery, the pyramidal tracts. The seat of the lesion in chorea, is therefore, the brain cortex and the pyramidal tracts, the great motor tracts must be fully developed before chorea can exist in a given case. In fact, chorea in the infant is unknown. Among the last four hundred cases at the Vanderbilt Clinic, the youngest was three and one-quarter years old and there were but nine cases altogether under five years of

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age. Chorea has, furthermore, been observed in dogs and monkeys in which animals the pyramidal tracts are well developed, while in animals below the scale of the dog, the pyramidal tracts are very rudimentary and chorea does not occur.

The motor manifestations of chorea are but one of the symptoms of this brain disorder. Because of their insistent and prominent character, they have long taken precedence over all other symptoms, many of which are of equal importance. The mental symptoms of chorea are of great importance. They are often of the same character, though lacking the serious nature, of the prodromal symptoms of mental disease. Such are, for example, the marked irritability of temper, changed character, capriciousness, defective memory, lack of power of concentration and attention, insomnia, night terrors, frightful dreams and illusions of the special senses, especially those of taste and smell. All these symptoms point again to the cerebral cortex as the seat of the lesion in chorea.

It is not my purpose to go into all the etiological factors of chorea. The matter of heredity, however, must be mentioned, since it is one of the most important factors in this disease. Nervous conditions of one sort or another in the parents are very frequent. Most frequently the mother will state that she has been nervous since childhood, or that the father is a very nervous man, and admissions of this sort usually mean much. We often observe the fretful, nervous, irritable mother, presenting her child for treatment. An insane heredity is a very bad omen and chronic manifestations in the children of insane parents, or parents who give an insane history, may be the precursor of dementia praecox in the child, or of permanent intellectual impairment. A case of this sort was recently seen by me in which at first it was very difficult to distinguish whether the boy, age 17, was suffering from chorea or the premonitory symptoms of dementia praecox. Unfortunately for the boy, it proved to be the latter. Another case, a child age 16, of neurotic parentage, but without insane heredity, presented choreiform symptoms in the beginning and was diagnosed chorea, but when first seen by me was in a condition of marked catatonia and presented a typical picture of the catatonic form of dementia praecox. The occurrence of choreic symptoms in a case presenting a bad mental heredity should be carefully watched and special precautions should be taken in its man-

agement and treatment.

We have said that the lesion in chorea is located principally in the cerebral cortex, a fact supported by (1) some newer facts in brain physiology, (2) the symptomatology of the affection, and (3) the inferences to be drawn from the influence of heredity upon the condition. Two further questions, however, confront us: What is the lesion of the cortex in chorea? What produces the lesion and what are its possible relations to other affections? When chorea was regarded as a simple neurosis, no lesions were found post-mortem. With the publication of the classical observations of Germain See about 1850, the relationship of chorea was first recognized. This relationship was emphasized by Roger, who published various brochures upon the subject in 1866, 1867 and 1868, and who first recognized the possibility of a common cause for rheumatism, heart affections and chorea. This opinion has received the gradual corroborative evidence of various writers, until at the present time its soundness is very generally recognized. Kraft Ebing in 1899 found changes in the heart valves in choreics, diagnosed as of hysterical origin. The statistical support to the common origin of the three affections is now quite complete. Meyer found heart lesions in a number of cases examined and called attention to the great frequency with which chorea in childhood was followed by rheumatism in after life. The common origin of the three affections is furthermore emphasized by the work of Poynton and Plaine of London, published three years ago, and also by the more recent work of Flatau, Jacobson and Minor of Berlin. These writers distinguish the choreas of the simple, acute type from the chronic conditions of the Huntington type by the term "infectious chorea."

What right have we to regard chorea as an infectious disease? The answer will be found in a study of the lesion underlying the condition and the elements producing that condition. The gross lesions found in the recent autopsies in cases of chorea consist of congestion and œdema of the pia mater and the cerebral cortex. The cells, especially the large pyramidal cells, are swollen and there is marked perivascular infiltration. In other words, there are inflammatory foci scattered throughout the substance of the brain and these inflammatory foci are along the vascular channels. Since the vascular supply of the cortex is a terminal system, the distribution of perivascular inflammatory products along it becomes especially serious,

since their removal is to be accomplished through the lymph channels alone. These lesions, however, are found everywhere throughout the cerebral substance. In fact, some cases give the picture of an encephalitis. The lesions found in the other organs of the body are those common to the acute conditions generally, and vary with the duration and severity of the affection. They are of the mildly parenchymatous inflammatory type and I need not dwell upon them. The heart affection (the most usual lesion) deserves a passing note. Vegetative products have been found upon the endocardium in most of the recent autopsies. These vegetative products may produce a thickening of the valves which may or may not be so placed as to give rise to a murmur. Where the heart has been carefully examined, I have been impressed with the great frequency of symptoms referable to it, more particularly with the frequency of a harsh or roughened first sound. Increased frequency of the pulse of from 10 to 30 beats per minute is very common.

What produces these various lesions and what are their possible relations to other affections?

Various micro-organisms have been described. The finding of a form of staphylococci in rheumatism some years ago, was followed by the description of a streptococcus by Wasserman and Malkoff, and the finding of the staphylococcus pyogenes aureus in the blood by Guizetti a little later. A streptococcus and staphylococcus were found also in the heart valves by Mayer. Cultures of these organisms were injected into animals by Wasserman and Malkoff and by Guezetti and the animals died of rheumatic manifestations or forms of septic infection, or from encephalitis, depending upon the point of injection. More recently this work has been corroborated by Pointon and Plaine. These writers found constantly a coccus in the heart lesions, identical in cases of chorea and cases of rheumatism, which, when injected into animals, gave rise to cerebral, septic and rheumatic symptoms. The evidence is practically conclusive that in acute chorea we are dealing with an infectious disease produced by micro-organisms; that this same micro-organism may give rise to heart lesions or rheumatic manifestations; if the cerebral hemispheres become involved chorea results; if other portions of the body, some form of acute rheumatism. The lesion in the brain consists of minute inflammatory masses about the smaller cor-

tical vessels.

What portion of the body forms the probable point of entrance of these micro-organisms?

For some years the association of tonsillitis and the rheumatic diathesis in children has been noted. In fact, a few years ago the association was regarded as so close that some writers were inclined to regard an acute follicular tonsillitis as a manifestation of rheumatism and even to so treat it. This proposition we now know was extreme, and the truth probably is that the tonsils form one of the foci at which bacteria may become latent in the tissues and subsequently give rise to trouble. I am fully aware of the fact that this whole question of latent infection is one of the battle grounds of bacteriology at the present day; but the facts are that the number of bacteria of a harmful character that can become latent in the tissues of the human body is gradually growing. Formerly we knew of but one and for a long time it was supposed to stand alone in this respect. I refer of course to the tubercle bacillus. It has been known for years that an apical tuberculosis of the lung might heal, the germs becoming encapsulated in the tissues, and that from this point as a focus of infection a tubercular process in the bone might be set up years afterwards, the germs having remained latent in the tissues for a long period. Living tubercle bacilli have been recovered from old, healed tubercular scars hundreds of times, and this property of this germ was, until quite recently, supposed to be unique, but we now know that there are numbers of other pathogenic germs capable of assuming latency within the tissues and this fact bids fair to explain many obscure points in medicine. It has recently been suggested, for example, that the ordinary streptococcus of septicæmia is one of these and certain cases of puerperal fever are thus explained; the virulent streptococcus of an acute ovaritis or appendicitis may become walled off during the healing process, the protective adhesions of which may subsequently become broken during a state such as labor, with the result of setting free within the tissues virulent micro-organisms which set up a septicæmia. All will agree that there are a few cases of puerperal sepsis which admit of no other explanation, and until recently this explanation was not forthcoming. The same is true of typhoid fever. The bacillus, after typhoid infection, has been recovered in pure culture from bone abscesses years subsequently. And

now we are coming to look upon the tonsils of children as points at which pathogenic bacteria, after having perhaps played the chief role in an acute inflammatory process, may become latent in the crypts and surrounding tissues and later give rise to rheumatic, choreic or other manifestations.

We might sum up the present status of our knowledge of simple chorea of the Sydenham type as follows: Choreia is an infectious disease produced by the presence in the brain tissue of a micro-organism, which micro-organism may also give rise to endocardial or rheumatic symptoms. The micro-organism may become latent in the tissues following some acute disease such as follicular tonsillitis, and subsequently give rise to a choreic attack should the vitality of the child become lowered from any cause so as to invite the invasion of the cerebral tissues by the latent micro-organism.

In conclusion, I desire to say a word regarding the management of chorea. The lesson to be derived from our study of the etiology and pathology of this affection is plain. Choreia belongs among the acute infectious diseases and should be so treated. This is a lesson which physicians are apparently slow in learning. To allow a child suffering from even the mildest type of chorea to go to school is pernicious. To allow them in the street playing with other children, or out of bed after seven o'clock in the evening, and to drink tea and coffee and eat sweets and pastries and other stimulating foods is disregarding the first principles of treatment. I am accustomed to enjoin the following regulations: The child must be taken from school and, during the first week, should be placed in bed and kept as quiet as possible. Other children of the family must positively be excluded from the room and nothing in the way of play or excitement allowed. In the afternoon the child may be dressed and taken for a walk of one hour's duration in the open air in company with an adult, preferably a relative. Upon returning from the walk the child should again go to bed. The sleeping hour should be preceded by a warm tub bath, temperature 98°, and of ten minutes' duration, followed by *no friction*. The soothing effect of the bath favors sleep in those cases where sleep is more or less disturbed. Moreover, it keeps the skin active. The diet should be plain, the main reliance being placed upon milk, eggs, vegetables and cereals, to the exclusion of tea, coffee, pastries, sweets and cake. Meat may be given once a day. After a week the child

may spend a longer time out of bed in the afternoon, and at the end of two or three weeks will merely remain in bed until late in the morning.

In the way of medication our main reliance is upon the salicylates and arsenic, preferably Fowler's solution. We may begin with two minims three times daily, after meals, and increase in three or four days one minim daily up to seven or ten minims, and then begin again with two minims. The larger doses are usually unnecessary. In my experience most cases get well upon a dosage of two or three minims three times daily after meals regularly for three or four weeks, provided the diet and mode of life, the baths and exercise can be regulated at the same time. Rheumatic or heart symptoms will indicate the need for salicylates. Should sleep be much disturbed and the child be very restless during the day, we may add three to five grains of Chloral Hydrate to a mixture containing two or three or four minims of Fowler's solution to the drachm. The effect of this mixture is usually a very happy one. In the later treatment the use of iron will be indicated to overcome the anæmia which is often a marked symptom.

Should adenoids or enlarged tonsils be present it is imperative that these be removed as soon as possible as a matter of treatment. The shock to the child need not be feared. Many cases needing such treatment improve but slowly until this measure is taken.

Dr. Richard Cole Newton, of Montclair.—

I read somewhere the other day that on a warship returning from the Orient were several Japanese servants. Some weeks after leaving the East, beriberi attacked four of these Japanese; there were no other cases on board. There was no assignable cause for these four cases. The only probable explanation was that they arose from a latent infection, such as has just been alluded to by Dr. Prout as a cause of chorea. Beriberi resembles in some respects chorea. It is supposed to come from eating musty rice or rice in some peculiar condition. But it is now said to be due to an excess of carbohydrates in the diet. Baron Takaki, and no man is better qualified to judge than he, emphasized the fact that the Japanese soldier cannot fight well unless there is a certain amount of meat in his diet, and other nutriment which contains a larger percentage of nitrogen than rice does.

While Choreia is surely quite infrequent in country and semi-country practice like my own, we do now and then see a case of it. And if we may judge from analogy and prognosticate the future from the past and the present, our turgid and ill-advised public school curriculum, bearing with greatest severity on girls approaching puberty, will surely, unless modified, lead to the

increase in this peculiar disease syndrome. The connection of the disease with rheumatism is too frequent to be disregarded. Holt and others are unequivocally in favor of this hypothesis, although Spiller (*Journal Amer. Med. Ass'n.*, Feb. 11, 1905) thinks that the relationship has been greatly overestimated and was unable to establish it in most of his cases. Taylor, however, says that 72 per cent. of choreic cases show evidence of rheumatic infection, and, if cases are included which show it in the family history, the proportion of cases in which the two conditions co-exist is so overwhelmingly large that a causative or synchronous connection between them must be admitted. Paynton, Paine and others have found micro-organisms in the brain or meninges, but if these are the cause of chorea it is still unknown whether they act by producing a toxin which affects the blood, or whether they act locally upon the nerve elements. They may act both ways. Capillary emboli have been found in the brain in cases fatal from associated endocarditis. It is by no means certain, however, that this condition is present in a majority of the rheumatic cases. Inasmuch as in nearly all of these complete recovery occurs in the course of a few weeks or months, any permanent structural change in the nervous centres is highly improbable. And the capillary emboli noted in two fatal cases are more probably the consequence of a severe and protracted muscular and nervous over-activity than the cause of it. Just as in epilepsy, the changes in the cortex, noted post-mortem, are more probably consequences of the spasms than their cause.

In cases not rheumatic the most likely explanation of the symptoms is to be sought in the vascular changes, which are due to disturbances of nutrition. Paynton pointed out some months ago that the micro-organism which produces rheumatic lesions in rabbits will also produce in them irregularity of movements, apparently similar to the choreic movements of children. The onset of the disease is usually gradual. The highest functions (those of the intellect) are first affected, so that the child becomes nervous and timid. (Fright is acknowledged to be the exciting cause in a certain number of cases.) Then irregular and spasmodic muscular movements begin, so that the child fidgets and grimaces. These conditions progress so that the whole disease syndrome becomes only gradually pronounced. It may, however, supervene with extreme suddenness and depart just as quickly. Meltzer has said that cholera is only a symptom and may be due to a variety of infections, such as rheumatism, pneumonia, scarlet fever, gonorrhœa, typhoid fever and in some cases syphilis. Burnet believes that even in rheumatic subjects chorea may be due to causes other than the rheumatic toxin, and gives two cases in which there were tapeworms present and in which the choreic symptoms rapidly subsided after the expulsion of the worms. Finley Bell reported a case of a woman pregnant three months, whose urine contained large quantities of indican diacetic acid and acetone, who was suffering with chorea. Investigation showed that she had been absolutely without food for three days. Under good food and eliminative treatment the chorea disappeared and pregnancy was completed without mishap. Noyes reported a case of chorea to the Academy of Medicine in February, 1905, in a pregnant woman 23 years old, with secondary syphilis, moderate febrile movement, hysteria, delirium at night, suicidal and homicidal tendencies, slurring

speech and failing memory, spasmodic twitching movements similar to the movements of Sydenham's chorea. She recovered completely after three weeks of anti-syphilitic treatment. As to the pathogenesis of the disease, the opinion has been recently expressed that the forms which are more or less chronic, such as the so-called Huntington's chorea, present many points in common with hysteria and epilepsy, and probably have a kindred pathology to the latter in the cerebral cortex. Holt says that the mental condition of choreic patients is essentially one of marked irritability. They are fitful, emotional, easily provoked to tears or laughter and difficult to control. In extreme cases the mental state borders on acute mania or may pass over into this condition (chorea insanien). He is of the opinion that the chorea may depend upon some ocular defect and the correction of this will form an essential part of the treatment, although few, if any, cases are cured by attention to the eyes alone. La Feta writes in the *Archives of Pediatrics* that cases of this disease are so rare in the fall of the year that it is almost impossible to collect what are needed for a nerve clinic in a large ambulance service. As the season advances, however, the number of cases of chorea gradually increase, until March or April, when there is a sudden rise in their number. Probably the most important exciting cause of those cases, not clearly rheumatic, is excessive stimulation of the cortical cells of the brain. This results in the gradual supervention of under-nutrition and consequently in over-excitability of these cells. Disregard of the premonitory symptoms of this condition, such as wakefulness, headache, anorexia, languor, peevishness, etc., etc., risks the more serious results of over-pressure, such as chorea, neurasthenia, hypochondriasis, hysteria, and even epilepsy and insanity in patients of neurotic heredity. Strasser says that the anemia may be so extreme that the hæmoglobin will not exceed 20 per cent., and that this cachectic condition is not to be looked upon as a secondary symptom, but rather as an important etiological factor of the disease. He calls attention to the fact that in ordinary rheumatic cases the rheumatic symptoms generally precede the endocarditis and the chorea. This order of precedence may be reversed and the chorea may be the first or the second of the lesions in the order of its appearance. Without taking up more time in discussing the etiology and symptomatology of this obscure and interesting complaint, it is very evident that we are as yet completely at a loss in regard to its true cause. It is extremely probable that more than one morbid process is going on in the body of the victim of this malady. Every step, such as Dr. Prout has detailed, which goes toward the elucidation of this mystery, is of extreme importance and has a bearing in several directions, not only toward the clearing up of the mystery which surrounds chorea, but certain other disease syndromes which are almost equally mysterious. The fact that a few cases have been reported in which injections of diphtheria antitoxin had a decidedly ameliorating effect on the spasmodic movements points strongly toward their toxæmic origin. Hamilton reports a case in the *Medical Record* of June 16, 1906, in which an extremely violent case of chorea insanien in a young man of 20 was controlled by injections of diphtheria antitoxin, one of 3,000 units, followed in a day or two by a second of 2,000 units. Nine years before he had seen a similar result in a child after the injection of antitoxin in a case

of diphtheria which had suffered for months with chorea. Strasser quotes a case in which thirteen to fifteen injections of antistreptococcus serum were given in a case of chorea in which streptococci had been discovered in the urine, and the patient recovered. Diphtheria antitoxin has been used in cerebro-spinal meningitis and Bowditch reported two cases of asthma, apparently very favorably influenced by it, to the American Climatological Association in 1898. It appears to have a certain amount of influence in certain spasmodic conditions in which an infection has occurred or in which, like asthma, there is a toxæmia from auto-intoxication. Reasoning, therefore, by analogy, chorea may be, and probably is, due to a toxæmia, which is doubtless caused by various factors. Perhaps the chief of these will be found to be an auto-intoxication from faulty metabolism due to the nervous depression of school life and unhygienic surroundings.

TREATMENT—W. C. Hoppeter advocated warm baths—from 90 to 96 degrees—for one to two hours, twice daily. The whole body to be immersed except the head and neck. The last ten minutes to be devoted to a gentle superficial massage. Of 40 to 50 cases so treated, he reports that the duration was reduced from twelve to six weeks. Apomorphine has been used in the treatment of chorea and with considerable success, but the use of tartar emetic is less dangerous in children than apomorphine. It is to be given once daily for three consecutive days in doses, respectively, of 0.02 gram, 0.03 gram and 0.04 gram. Then, after an interval of three to five days, another series of doses is given for three days, .03 c.c., .04 c.c. and .05 c.c. It may be necessary even to give a third course. This remedy has also been used advantageously, as Dr. St. John has pointed out, in tetanus and cerebro-spinal meningitis.

Dr. George H. Balleray, of Paterson.—I think the Society is indebted to Dr. Prout for the presentation of his very interesting paper. Choreia is particularly a disease of children, and the particular interest in it lies in the consideration of the pathology and treatment.

I think the treatment suggested ought to exercise a marked influence on the disease, and I hope the general practitioner will be impressed with what was stated in regard to quiet.

With regard to the treatment of certain nervous affections by the antitoxin method, it would seem that by some practitioners it has been found that the diphtheria antitoxin is a specific for everything from the irritation of teething to the bite of a mad dog. I think that most of the cases reported as having been cured by anti-diphtheritic serum were judged on the basis of *post hoc ergo propter hoc*. The serum was given; the patient got well. Therefore, the serum cured him. My own impression is that the administration of the serum had nothing to do with the recovery. It simply illustrates the vagaries that take possession of the minds of practitioners who are anxious to be ultra fashionable in their therapeutics.

Dr. Walter B. Johnson, of Paterson.—The Society is to be congratulated upon having heard such an excellent paper. There are two things I should like to ask the doctor. The first one is, if the pathological lesion is located in the membrane in the vicinity of the cerebral cortex, why certain cases of chorea show themselves almost

entirely by twitchings of the mouth, or blepharospasm, or movements of the ear, or forehead?

I should like to hear the doctor explain why these latent bacterial elements which have lodged in the faucial tonsil and remained latent for an indefinite length of time suddenly become active. I should like to have him state whether, in his opinion, the latent bacilli gained an entrance into certain pathological parts of the body through the circulatory or lymph channels, selecting special points of deposit and germinating actively. Why in certain cases of infection of the cervical glands does the surgeon say, this disease is the result of a direct infection from the tonsil and it is tubercular; then the pathologist will say that he has examined the lymph nodes of the tissue removed at operation and they are the seat of tuberculosis. But if you pin the pathologist down tightly in the matter he will say that he called it a tuberculous gland for the reason that he discovered certain arrangements of tissue, certain areas of caseous degeneration in the gland, and the arrangement of round cells and possibly giant cells would indicate to him tuberculosis was present. But if you asked him, "Have you examined for the tubercle bacilli?" he will answer, "No," and that is the last you will hear of it. I say the pathologist is too ready to make a diagnosis of tuberculosis from the arrangement of the tissues and the pathological appearance of the growth. I believe before a diagnosis of tuberculosis in any tissue is made that the bacilli should be actually demonstrated to be present in the tissues or should be shown by actual culture from them and that animals injected with the germinal products could actually develop the disease. Perhaps I am not as conversant with the particular bacilli of rheumatism, which is supposed to be the one found in the membranes of the cortex, but I would like to know as a matter of information whether in cases of chorea which have died, and examination made, if that examination was sufficiently complete to demonstrate the actual presence of the particular bacilli which is supposed to be there. It is a strange thing that the treatment of the disease to-day is the same as it was years ago before any form of bacilli was discovered. Fowler's solution is the mainstay, and it always has been the mainstay. I do not know whether it is satisfactory in the treatment of rheumatism, because I have no occasion to treat rheumatism. But I would like as a matter of information to know if anything has been discovered that would positively indicate the actual presence of a disease bacillus.

Dr. Henry L. Coit, of Newark.—I want to congratulate Dr. Prout for presenting one of the best written and most important papers heard at this meeting. I am sorry that I must wait until the paper is printed in the JOURNAL before I can study it and make it actually my own. It is precise, complete and fundamental. I think every man present should take pains to know thoroughly what he has taught us.

Nothing has been said regarding the mortality of the disease. The books teach us that the prognosis in chorea is good. While the mortality is not great, still it is possible that the disease may end fatally. Sinkler states that there were 64 deaths in 74 years in Philadelphia. An interesting case, terminating fatally, was recently reported by Dr. J. P. Crozer Griffiths, of Philadelphia, because of violent muscular action. That is

so rare that I wish to report a case of my own which did not result in death. The patient was the child of a physician in my own town, who for three or four weeks had been suffering from chorea. The child was an only one and the mother was a neurotic subject. The child had been spoiled, was indulged, diet poor, the management bad. The child had fever and for three weeks had been treated for malaria. When I saw the child it was lying in bed with violent universal muscular action. The extremities were all in violent contraction. The child was then getting large quantities of quinine. I found an old systolic murmur which was heard over the entire precordium and transmitted to the axilla and heard near the angle of the scapula. I advised stopping the quinine. Calomel was given, with a restricted diet for a few days. Arsenic was introduced and increased in doses, but with no relief. Resort was made to all sorts of sedatives. The child was covered with ecchymotic spots from the bruising. Sometimes when left alone for a few minutes the mother would find the child in a remote corner of the room, or even under the bed. The situation was extreme and so serious that we resorted to bromides, hyoscine and other powerful nerve sedatives, but to no purpose. I had somewhere seen suggested apomorphine in the treatment of chorea. We began to give 1-100th of a grain every three hours and before twelve hours had elapsed the child's muscular contractions were a great deal more moderate, and in two days there were none whatever. At the end of one week the child was sitting up quietly. I simply report this case of chorea to illustrate the possibilities of apomorphine.

Dr. Margaret P. Brewster, of Grantwood.—Two years ago, at the Presbyterian Hospital clinic in New York City, we had a great many cases of chorea. That summer the chief of clinic was away, and I had charge during the summer. It seemed to me that the medication did not make any difference in these cases. We took 30 cases; 10 were treated with arsenic, 10 with rhubarb and soda, and 10 received no medicine at all. All were on the rest treatment, absolutely at rest in bed, were given cold packs and a carefully regulated diet. It seemed to me that the cases with no medication practically got well in the same length of time as the others. All got well in from four to twelve weeks, except one, which was a third attack, and this case went into a children's hospital and was lost sight of after about four months.

Dr. Thomas P. Prout, of Summit.—With regard to the micro-organisms of the disease, it should be remembered that there have been but very few autopsies, since chorea is not usually fatal. In the large number of cases that I have seen, there has been but one fatal case, and in that case there was no autopsy. I killed a dog suffering from acute chorea about a year ago and the lesions there found are the only ones I have carefully studied. There were inflammatory foci in both the cortex and basal ganglia. The autopsies have been so few and opportunity for investigation so rare, that the relationship between a lesion of the tonsils on the one hand and lesions of the brain on the other, has not as yet been proven. The frequently limited character of the twitchings mentioned by Dr. John-

son, I believe, are thus explained: In many cases the area of the brain involved is limited; there is not a general encephalitis. We not infrequently see cases of hemi-chorea; an occurrence to be explained by the involvement of one cerebral hemisphere only. If the portion of the brain involved is sufficiently limited, the muscular involvement will be correspondingly limited. The almost complete limitation of the muscular movements to single extremities is not infrequently seen.

As regards the therapeutics of this condition, I think the regulation of the mode of life and the hygiene of the child are of the greatest importance. The hygienic side of the treatment is so important that we have recently had cards printed for the clinic, on which is detailed at considerable length the mode of managing a given case, and one of these cards is given to the mother for her guidance. Of course, the matter of medication is also important.

I recently saw a case occurring in a child about five years of age that well illustrates some of the points in my paper. There was first a tonsillar infection, then the child developed rheumatic symptoms, which lasted four or five days, and were followed by chronic manifestations.

Reports from County Societies.

BURLINGTON COUNTY.

George E. Tracy, M. D., Secretary.

The annual meeting of the Burlington County Medical Society was held in Masonic Temple, at Mount Holly, N. J., January 9, 1907, at 4 P. M. There was a large attendance of the members.

Dr. Lyman Hollingshead, of Pemberton, was elected to membership. The following officers were elected for the ensuing year: Dr. Joseph Stokes, Moorestown, President; Dr. C. D. Mendenhall, Bordentown, Vice-President; Dr. G. T. Tracy, Beverly, Secretary; Dr. E. Hollingshead, Pemberton, Treasurer; Dr. W. P. Melcher, Mt. Holly, Reporter; Dr. F. G. Stroud, Moorestown, Censor for three years; Dr. W. H. Shipps, Bordentown, and Dr. R. C. Barrington, Mt. Holly, annual Delegates to State Society.

Dr. Philip Marvel, of Atlantic City, Councilor from the fifth district, was introduced and stated that he had come by request of Dr. W. H. Iszard, who was suffering from an attack of "la grippe." Dr. David C. English, of New Brunswick, was introduced and extended the usual courtesies of the Society. Dr. Philip Marvel read an exhaustive report of the itinerary work done by Dr. J. N. McCormack, of the American Medical Association. A committee of three—Drs. Parsons, Marcy and Shipps—was appointed to act in conjunction with the President and Secretary, to arrange for a meeting of physicians and the public, with Dr. J. N. McCormack, February 18, 1907.

A resolution was adopted requesting the

President of the State Society of New Jersey to appoint a committee of five, who shall prepare and issue a statement to the public on the question of medical examiners' fees and how it affects the welfare of life insurance policy holders.

An hour of refreshment was declared and all retired to an upper room to meet the wives of the members and other guests of the Society who were being entertained at tea by the wives of the Mt. Holly physicians. Dinner was announced at 6.30 P. M. and members and guests sat down to a well-served dinner.

After dinner, Dr. Joseph Stokes read the President's Annual Address. In the absence of Dr. Chandler, Dr. D. C. English responded to the toast, "The State Society; Its Past, Its Present, Its Future," as well as to the one on which he had been invited to speak, "Medical Journalism: The Journal of the Medical Society of New Jersey." "The Medical Man in Politics" was ably responded to by Dr. L. M. Halsey, as was "Medical Legislation: What It Has Done and What It Should Do for the People," by Senator S. K. Robbins.

GLOUCESTER COUNTY.

W. Grant Simmons, M. D., Reporter.

The regular fourth quarterly meeting of the Gloucester County Medical Society was held Thursday afternoon, December 20th, at 1:30 o'clock, in Paul's hotel, Woodbury.

There was a good attendance and great interest manifested in discussing epidemics and interesting cases.

An interesting paper on "Vaginal Tears Produced During Labor and an Operation for the Same," was read by Dr. Swithin Chandler of Philadelphia.

On motion the reporter was instructed to send a copy to *The Journal* for publication.

Dinner was served at 4:30 o'clock.

MERCER COUNTY.

At the last monthly meeting of the Mercer County Component Society the preliminary report of the committee on Insurance of the American Medical Association was read and discussed and the following resolution was unanimously adopted, a copy of which the officers were directed to forward to the *JOURNAL*:

RESOLVED: That we, the members of the Mercer County Component Society of the Medical Society of New Jersey, in accordance with the recommendations of the Committee on Insurance Fees of the American Medical Association, do hereby pledge ourselves unitedly to make no ex-amination for Life Insurance Companies for a less fee than five dollars.

D. B. Ackley,
President.

J. J. McGGuire,
Secretary.

ORANGE MOUNTAIN MEDICAL SOCIETY

At the annual meeting of the Orange Mountain Medical Society, held January 18th, in the rooms of the William Pierson Medical Library Association, the following officers were elected: President, Dr. Davis H. Van Gieson, of Bloomfield; vice-president, Dr. Harris E. Matthews, of Orange; treasurer, Dr. James Minor Maghee, of West Orange; secretary, Dr. Richard D. Freeman, of South Orange, and reporter, Dr. Walter Dodge, Orange. Drs. H. E. Matthews, D. H. Van Gieson, R. D. Freeman, W. J. Chandler and Mefford Runyon were elected members of the executive committee. The following were appointed censors: Dr. Thomas W. Harvey and John H. Bradshaw of Orange.

NEW MEMBERS OF THE AMERICAN MEDICAL ASSOCIATION FROM NEW JERSEY.

Cobb, G. H., South Orange.
Hance, Irwin H., Lakewood.
Langdon, R. M., Englewood Cliffs.
Mander, A. J., Millville.
MeVay, J. C. F., Atlantic City.
Muta, Samuel A., West Orange.
Rosensohn, William, East Orange.
Runyon, Mefford, South Orange.
Scheppach, Harry A., Newark.
VanSyckle, Alva C., Hackettstown.
Ames, Elmer H., Jersey City.
Alexander, W. S., Newark.
Carman, Fletcher F., Montclair.
Harbert, G. Eugene, East Orange.
Hardenberg, Daniel S., Jersey City.
Seibert, Edgar C., Orange.
Sprague, E. W., Newark.
Mills, Andrew M., Newark.
Vaughan, Harry, Morristown.

NEW MEMBERS OF THE SOCIETY FOR THE RELIEF OF WIDOWS AND ORPHANS OF MEDICAL MEN OF NEW JERSEY.

E. S. Corson, Bridgeton.
Josiah Meigh, Bernardsville.
Arthur Stern, Elizabeth.
Thomas E. Dolan, Elizabeth.
Edgar K. Conrad, Hackensack.
Alvah A. Swayze, Hackensack.
B. Van D. Hedges, Plainfield.
C. W. Croulshaw, Newark.
Walter J. Jacquith, Newark.
Alfred T. Halstead, Newark.
Theodore E. Bleick, Newark.
George A. Rogers, Newark.

Deaths.

ARD. In New York January 20. Dr. William E. Ard, brother of Dr. Frank C. Ard, of Plainfield, N. J. He graduated from the University of Maryland in 1891; practised in Binghamton, N. Y. and during the last three years in New York City.

JENTZ. At Hasbrouck Heights, Bergen County, Dec. 20. Dr. Otto F. Jentz, from intestinal obstruction, aged 62 years.

MORRIS. In Astoria, Long Island, on January 1. Dr. Theodore F. Morris, of Jersey City, aged seventy-five years. He graduated from the Bellevue Hospital Medical College, 1863.

THE JOURNAL

OF THE

Medical Society of New Jersey.

FEBRUARY, 1907.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any one failing to get the paper promptly will confer a favor upon the Publication Committee by notifying them of the fact.

All communications relating to the JOURNAL should be addressed to the Committee on Publication, 95 Essex Avenue, Orange, N. J.

IMPORTANT ANNOUNCEMENT.

We call the special attention of every member of our profession to the visits of Dr. J. N. McCormick, of Kentucky, to the various County Societies of our State during the month of February. The accounts which come to us from other States demonstrate that Dr. McCormick's addresses have been of incalculable value to the profession as he has set forth the imperative necessity of, and the advantages arising from, a thorough organization of the medical profession. We announce in another column the date of his visit to each society, and urge every member of every society so to arrange his professional, social and other engagements that nothing but the most emergent call of duty shall interfere with his attendance on the meetings of his County Society. We say meetings because it is desirable that each society shall arrange for two meetings, one for the members only, to be followed in the evening by a general meeting, to which prominent citizens have been invited, especially professional men—ministers, lawyers, educators and also legislators, municipal officers and business men of influence in the community. Where all the members can not give an afternoon and evening to this work some societies are arranging for a six o'clock meeting for the members to confer with Dr. McCormick, at which light refreshments will be served and the public meeting to be addressed by him at eight o'clock. But whatever plan is adopted, let every member be

willing to make some sacrifice of time and money if need be. We believe it will be time and money well invested which will bring large returns.

OUR STATE SANATORIUM.

The fifth annual report of the Board of Managers of the New Jersey Sanatorium for Tuberculous Diseases, for the year ending October 31, 1906, has just been received. It conveys the good news that the buildings are practically completed and that the Sanatorium will be ready for the reception of patients in the spring of this year. The contract for the water supply has been awarded for the sum of \$13,919, and one of our ablest civil engineers, M. R. Sherrerd, City Engineer of Newark, has been engaged as consulting engineer for this system. The contract for the sewage disposal plant has also been awarded for \$6,740, and Prof. Chas. McMillan, of Princeton, has been retained as consulting engineer for that plant. It is also very satisfactory to note the care that has been exercised in awarding other contracts, that they should not only be given to the lowest bidders, but that adequate bonds have been secured for their satisfactory execution. Special care has been given to drawing up and awarding the contract for the equipment, furniture, bedding, kitchen utensils, &c., specifications for which were prepared by Dr. Walter J. Marcley, superintendent of the Massachusetts State Sanatorium, thus securing a tested and practicable equipment.

The managers estimate the need of further appropriations by the State as follows: \$20,000 for professional apparatus, or drugs, medicines, appliances for local treatment, &c.; \$25,000 for the building of roads in order to render the buildings accessible; \$25,000 for the maintenance of the Sanatorium from May 1st, to October 31st, 1907, and of \$50,000 from November 1, 1907, to October 31, 1908. The expense of patients per capita is reckoned at \$8.83 per week, which for one hundred and eight patients (the full number capacity) for a year would amount in round numbers to \$50,-

ooo. This is the lowest expense per capita at the Massachusetts Sanatorium from 1894 to 1896, and after their long experience it would not be expected our sanatorium could be conducted at a less rate per capita.

The report contains the financial statement and the reports of the architect, Consulting Engineer Sherrerd and Prof. Chas. Mc-Millan. The report is signed by Drs. Chas. J. Kipp, chairman; Wm. S. Jones, John H. Moore, Theo. Senseman, Elmer Barwis and James S. Green (all members of our State Society), Austin Scott, LL. D. and A. L. Beavers.

Notwithstanding the fact that some have questioned the wisdom of the expenditure made for this sanatorium before a chance has been given to test it, we believe, from the results of the Massachusetts State and other sanatoria, and the importance of using every means to lessen and ultimately prevent a disease that is annually causing nearly 4000 deaths in our State, that the criticisms are ill advised. We therefore congratulate our Society (which inaugurated this movement) and the people of our State on the prospect of the speedy completion of this greatly needed Sanatorium which our State has wisely provided for the relief and life-saving of its sorely afflicted citizens, which means the saving of thousands of lives and millions of money to the State. We must not lose sight of the fact that its capacity is limited to the care and treatment of only 108 patients at a time, or possibly of 400 during the year, while there are thousands within our borders who need relief and for whom we must provide if this greatest of all scourges that afflict humanity is to be controlled, and in time eradicated. Every county should have its sanatorium and every large city should provide, if not a sanatorium, at least a day camp where its tuberculosis cases could be provided with proper care and treatment which if not resulting in the saving of the and restoration to health of the affected in all cases, would at least tend to prevent the diseased from infecting others.

It should be borne in mind in speaking of

108 as being the full number of patients treated at a time, that this Sanatorium is for *incipient* cases of tuberculosis. (indigent patients only being admitted) most of which would probably remain in the sanatorium from two to four months only, so that during the entire year the 108 beds would really provide accommodation for four or five hundred patients. This number might be increased to about 200 at one time, or seven or eight hundred during a year, by the use of tents.

LIFE INSURANCE FEES.

In the January issue of this JOURNAL we indicated our intention to deal fairly with the insurance companies in the matter of medical examiners' fees. We have since then discussed the questions involved with several medical directors of companies paying both the \$3 and the \$5 fees. They all state that they are all perfectly willing to pay some medical examiners a five-dollar fee, but that a large number of their examiners' work is not worth even three dollars and some is not worth one dollar per examination; that it is surprising from some of the smaller towns, especially in remote sections of our country, how much incompetence is indicated by the reports received, and that even in some cities in our own and neighboring States carelessness is shown and that through their detective agencies they have found instances, in many cases, where the examiner made urinalysis reports when he had never had a specimen of urine given him to examine. Now, we fully agree with these medical directors that examiners who are as incompetent as they represent, and especially such as show dishonesty, should not receive five dollars, or even three, and we will go further and express our judgment that they should be dismissed from the company's service.

But why should the competent and faithful examiners, whom, we believe, constitute the vast majority, be placed on the same level with them, and why are the incompetent and dishonest, whom we believe to be few in number, very few of the regular school,

retained? Is it just to the policy holders that a lot of bad or doubtful risks should be accepted and the safety of the company and of their policies should be endangered? But, say these medical directors, "these examiners are as good as we can get in their sections." Well, then, would it not be far better for the companies to withdraw their business from such sections, if they can not afford to pay competent and reliable physicians an extra fee to go there and make the examinations?

Again, if the competent and conscientious examiners are inadequately paid and resign because of that fact, are the companies likely to gain anything by the employment of cheaper men? Will not the number of the incompetent and dishonest be largely increased, and will not the company that resorts to that policy lose the confidence of the public generally, as well as that of the medical profession? Now, most of the medical directors have given us to understand that the companies *can afford to pay the five dollar fee to competent examiners who serve them faithfully*. Let the companies, then, pay the five dollar fee to every examiner who serves them acceptably and employ only such as are competent and honest and generally acceptable. Our medical society has during all its 140 years' existence endeavored to raise the standard of medical education—it will have no controversy with our life insurance companies if they are really for their own and their policy holders' protection, seeking to weed out the incompetent. We will rather welcome their aid in raising the standard as they recognize the proper educational qualification for the practice of medicine and for service as medical examiners for life insurance. We also assure them that the Medical Society of New Jersey will not stand for the dishonorable acts of any member of the profession, whether he be inside or outside the society's membership.

We call attention to the letter of Dr. W. J. Mayo, President of the American Medical Association, in reference to medical examiners' fees, and the report of the Committee

of the American Medical Association on the subject, which will be found elsewhere in this issue of the JOURNAL.

RAISING THE STANDARD OF MEDICAL EDUCATION.

We have referred to the efforts of our State Society to raise the standard of medical education. It is very evident, from the statements contained in a communication from Dr. E. L. B. Godfrey, which appears in another column, and from the efforts of osteopaths and other irregulars who are improperly claiming the honorable title of M. D., and are demanding recognition and legal authority to impose upon the credulity of the public as qualified practitioners, that there is pressing need of increased effort to protect the public by maintaining the only true position—that the educational qualification shall be the basis in determining the legal authority of any person to treat disease, deformity or injury by any method whatsoever. It matters not whether that person be a pretender who practices a false system of medicine or one who has pursued the prescribed course of a medical college, and has received a diploma therefrom. One of the most imperative needs in our effort to secure and maintain a high standard of medical education is a stringent law which will compel the defective colleges to raise the curriculum improve their methods of instruction and increase their requirements as to the student's knowledge in the examination which precedes the granting of diplomas. Dr. Henry Beates, president of the Pennsylvania State Board of Medical Examiners, calls attention to the fact, in the *Public Ledger*, of Philadelphia, December 20th, that twenty-six young men failed to pass their board at the recent examination, and that 23 per cent is about the average of failures. He says: "Any medical college is committing a crime which graduates a man who, after four years of training therein, gives such answers as were given at the State Board's recent examination. It is a crime because, in the first place, it is obtaining money under false pretenses in that it grants a diploma to an indi-

vidual who is not a doctor in the understanding of the term, and who, if by any chance he could pass a state board, would be a menace to the health and life of any individual who would be unfortunate enough to be under his care." The doctor cites the answers given to a few questions asked the candidates for licensure, and says: "About one-quarter of the papers show a degree of illiteracy that renders the candidates for licensure incapable of understanding medicine."

In our own State, at the recent examination by the Board of Medical Examiners six candidates were refused examination because of very deficient preliminary education, and 27 per cent. of the applicants examined were refused license to practice because they failed of the required standard. We agree with Dr. Beates that "the law creating the present practice rights should have been originally framed directly to control the medical college instead of its unfortunate victims." Proper preliminary education should be a *sine qua non* for matriculation in a medical college. Harvard's medical department, we believe, requires a college diploma. Should not every other medical college? Will any amount of medical instruction produce scientific practitioners of medicine when the preliminary education has been sadly deficient? The practice of medicine to-day requires our "brainiest young men" whose minds during the early years of preparation have not been simply crammed with facts and figures, but have been trained to think correctly and to form logical conclusions as the facts and figures are understood, and their import comprehended. Such young men after proper instruction in a reputable medical college will practice as scientific medical men and the outcome will be (1) the elevation of the medical profession through its advance in scientific knowledge and the art that applies it and through the elimination of the evils of inadequate fees contract practice, nostrums and false pretenders; and (2)—which must of necessity follow as the result of the first—the incalculable blessing to suffering humanity.

DR. McCORMACK'S VISIT.

The Board or Councillors of the Medical Society of New Jersey, Drs. Marvel, Harvey, Leal, Clark and Iszard, in announcing the visits of Dr. J. N. McCormack to the County Societies, says

Dr. McCormack's experience in his work for the past five or more years, during which time his labors included visits to nearly, if not, all of the States and territories in the Union, has eminently fitted him for the work assigned. Perhaps few, if any have had greater or even similar opportunities to observe the needs of the profession, and acquired a better knowledge of how to meet the same than he. His office has necessarily brought him into contact with the questions affecting the professional and business relations of the physicians and the public, and it is especially the latter to which Dr. McCormack will address himself when visiting in our State. Little, if anything, further need be said concerning the subject of the Doctor's visit to New Jersey, and the results will necessarily depend upon the individual interest taken by the members and the officers of the component Societies. If 'twere possible for your Councillors to impress upon each one a clear understanding of the work he is doing, and the interest that has attached to meetings held in Michigan during his recent visit there, nothing more than an announcement of the dates and places of the meetings would be necessary to insure large and enthusiastic audiences. He is not going about, as some have supposed, admonishing the profession, telling them to be good, holding "love feasts" or organizing the organized, but rather to interest the public in an organized profession, instructing all as to what organized medicine should mean, and how to uproot the more or less inherited antagonisms which blight social advancement in too many communities, and prohibits both professional and public progress. Every one acknowledges many of the present day evils, yet how few dare to oppose their progress by open, honest measures? Too often one's efforts, when pursued alone, are misjudged and mis-stated.

Dr. McCormack seeks to enlighten the profession and the public on the subject of organized medicine and to show the latter that medicine has no interests that are not the interests of every individual living in the community. He thoroughly believes that were the profession better paid, had they more leisure for study and research; and if their motives in legislation were better understood, their influence as citizens would

be greater and their skill as physicians more helpful. To deal intelligently and justly with the Medico-Social evils which through legislation and otherwise are being forced upon the people against the judgement of the profession, requires a knowledge of the commercialism behind the trade in nostrums, proprietary and patent medicines, and as well, an acquaintance with the motives that popularize lodge and contract practice, beneficial orders, insurance and corporation fees, etc., therefore we should welcome with enthusiastic audiences the visit of Dr. McCormack, and use our greatest endeavors to secure for him an attendance of representatives of all the professions, legislators, municipal officers, members of Boards of Health, Civil Clubs, Bankers and all representative citizens at the evening sessions.

The Committees will arrange for two meetings in each County, for the medical profession alone in the afternoon and for the profession and public in the evenings. Arrangements, however, will be made for those County Societies where the meetings are small and almost wholly in a country districts, to hold both meetings on the same evening, having Dr. McCormack meet the physicians an hour earlier than will be arranged for the public.

ITINERARY OF DR. J. N. MCCORMACK

February 1—Essex County, Newark, Free Library building, 8 o'clock P. M.

February 2—Morris County, Morristown.

February 4—Warren County, Belvedere.

February 5—Sussex County, Newton, Cochran House, 2 P. M.; court house, 7.30 P. M.

February 6—Passaic County, Paterson.

February 7—Bergen County, Hackensack.

February 8—Union County, Elizabeth.

February 9—Hudson County, Jersey City.

February 11—Middlesex County, New Brunswick.

February 12—Somerset County, Somerville; Ten Eyck House, 3 P. M.; Assembly Hall, Public School, 8 P. M.

February 13—Hunterdon County, Flemington; meetings at 10 A. M. and 3 P. M.

February 14—Mercer County, Trenton; meetings at 3 P. M. and 8 P. M.

February 16—Monmouth and Ocean Counties, Asbury Park.

February 18—Burlington County, Mt. Holly.

February 19—Camden County, Camden.

February 20—Gloucester County, Woodbury.

February 21—Cumberland County, Bridgeton.

February 22—Salem County, Salem.

February 23—Cape May County, Cape May.

February 26—Atlantic County, Atlantic City.

THOMAS W. HARVEY, M. D.,
Secretary Board of Councilors.

Dr. James Hunter, Jr., of Westville was elected one of the coroners of Gloucester County November 6.

EDITOR'S EXPLANATION.

We have been compelled on account of a strike among the employees of the Company which prints our Journal, to delay this issue, and our members will please understand that this strike will also account for any errors or faulty appearances in this issue of the Journal.

An editorial on typhoid fever epidemics, a list of new and non-official remedies and the first portion of the Report of the Council on Pharmacy and Chemistry of the American Medical Association are necessarily deferred till the March issue of the Journal.

Miscellaneous Literature Items.

Chloral Hydrate in Scarlet Fever—

Dr. B. Franklin Royer, of Philadelphia, has a paper in the January 15th issue of *The Therapeutic Gazette*, on "An analysis of the Kidney condition of eight hundred cases of scarlet fever treated with routine doses of chloral hydrate; the analysis contrasted with seven hundred and fifty-six cases having the usual remedies." The paper gives the results of a study beginning in the latter part of 1904 in The Municipal Hospital of Philadelphia, to determine the value of chloral hydrate in the treatment of scarlet fever. He quotes Dr. James C. Wilson's advocacy of it in 1896, who believed that an increased diuresis was secured in from 36 to 48 hours after the administration was begun; that in some way chloral protects the functioning part of the kidney tissues, that the nervous symptoms are greatly modified; that the itching is allayed and the patient is made more comfortable. Dr. Royer states that he began his own study skeptical as to the value of this drug in scarlet fever. We give below Dr. Royer's conclusions:

First, chloral hydrate is of distinct value in the treatment of scarlet fever, and when used in doses of sufficient size to secure light somnolence does not seem to be a circulatory depressant. Second, chloral hydrate ameliorates nervous symptoms better than any remedy yet suggested in the treatment of scarlatina. Third, chloral hydrate allays the itching of the skin often found annoying in scarlet fever. Fourth, when chloral hydrate is given routinely during the febrile period and for some days thereafter, post-febrile nephritis appears to be less frequent. Fifth, this study would seem to justify the more extended use of chloral in the treatment of scarlet fever, and a more detailed study as to how it acts on the kidney itself.

Gastroenterostomy—Points in Technique—

The most frequent source of bad results after this operation is a position of the fistula causing the food to enter that part of the bowel which leads back to the stomach, and Delaloye (*Deutsche Zeitschrift für Chirurgie*, LXXXIII, 6) proposes certain factors which he thinks lead to the bad

results. The first point is that the loop of the intestine selected must be as close as possible to the stomach, and not the first loop that comes to hand; secondly, it should always be sewed antiperistaltic. The third point is that the opening in the stomach must not be larger than the lumen of the loop of bowel. If these rules are followed there will probably be no trouble.

Therapeutic Gazette, Jan. 15, '07.

Tendon Tissue Versus Catgut Ligatures.—Dr. Senn is convinced that from a commercial, scientific and practical point of view tendon tissue is destined to take the place of catgut in the armamentarium of the surgeon, and in the operating room of hospitals, both in military and civil practice.

Diagnosis and Surgical Treatment of Cerebellar Tumors.—Dr. B. Sacks declares that other things being equal, rapidly advancing optic neuritis may serve as a symptom pointing to cerebellar tumor. The early development of unilateral or bilateral rectus externus palsy is to be given due weight. He regards this symptom as almost pathognomonic of cerebellar lesions if it is associated with the general symptoms pointing to increased intracranial pressure. Sachs believes that when the diagnosis is made and when there is a fair degree of certainty as to the special part involved, a large trephine opening should be made over the suspected area. Even if the neoplasm is not found, much good will be done by the relief of pressure.—*N. Y. Medical Record*, Dec. 22, 1906.

One Hundred Consecutive Laparotomies.—Drs. Marshall and Quick, Appleton, Wis., give the mortality as 2 per cent. There were 18 cases of chronic appendicitis. Some patients were operated on after a single attack in which local tenderness persisted; several were operated on after the second attack, and a few after a dozen or more attacks. The writers do not advise operation after a single attack has subsided, but they invariably advise it after the second. They do not consider any case helpless or any patient too ill to stand an operation so long as the radial pulse can be felt.—*Medical Record*, N. Y., Nov. 24.

Shock.—Beddard says that alcohol and ether used to be given in the treatment of shock in the belief that they were cardiac stimulants. It is now known that they are not, and, furthermore, a cardiac stimulant could be of no real value in the treatment of shock, because no increase in the heart's action can counteract the fall in arterial-blood pressure caused by loss of the peripheral resistance. We may, therefore, conclude that alcohol and ether are useless, and it is probably true that they are therapeutically harmless in the doses usually administered. The pathology of shock makes it clear that the only useful drug would be one which raised the blood pressure by increasing the peripheral resistance, not through the vasomotor centre, but by acting direct upon the peripheral arterioles; and in adrenalin we possess such a drug. Adrenalin given by the mouth to patients other than those suffering from Addison's disease has practically no effect upon blood pressure because it is not absorbed from the alimentary canal. In shock adrenalin must be given either subcutaneously or intravenously. Adrenalin given subcutaneously

in therapeutic doses produces a temporary glycosuria, but is otherwise harmless. A safe dose for an adult is from 20 to 30 minims of a 1 in 1,000 solution. Its effect upon the blood pressure comes on within a very few minutes and has gone in about an hour, therefore the injection has to be repeated about every hour until the shock has passed off. Given intravenously, the effect of adrenalin is instantaneous and it does not last more than ten minutes. It is, therefore, necessary to infuse continuously a weak solution, such as 1 in 20,000.—*Clinical Journal*.

Gunshot Wounds in the Abdomen.—Stated in the order of their fatality, military surgeons of the widest experience have set down the following list for gunshot wounds of the abdomen: 1. Wounds of the spleen are the most fatal of all. 2. Perforating wounds of the small intestine and mesentery. 3. Wounds of the stomach. 4. Wounds of the large bowel. 5. Wounds of the urinary bladder. 6. Wounds of the liver. 7. Wounds of the kidney. 8. Nonperforating wounds of the intestine.—*N. Y. Med. Record*.

Chronic Icterus.—Claus and Kalberlah reports the histories of two brothers who suffered from chronic jaundice and, after consideration of the literature on the subject, conclude that there are two forms of this disease, one congenital, the other not. In many families there is a predisposition to jaundice, which is indicated by the absence of bilirubine from the urine, sometimes by the presence of urobilin, by discoloration of the stools, by a moderate degree of anæmia with relatively slight disturbance of the general condition, and eventually swelling of the spleen and liver. The severer or milder onset of the last symptom is an indication whether the condition is congenital or not.—*N. Y. Med. Jour.*, Dec. 22, 1906.

Amyl Nitrite in Hemoptesis.—Inasmuch as the nitrites are classified with the cardiac stimulants, the average practitioner is apt to overlook the fact that their effect on the heart is only a secondary one, or, at any rate, mainly so. At first sight, it would seem homicidal to order a cardiac stimulant to a patient with pulmonary hemorrhage, and this indeed would be the case if amyl nitrite were a direct cardiac stimulant. We know, however, that the action of most importance is the dilatation of the superficial capillaries, and that the effect on the heart is mainly due to the fact that this capillary dilatation reduces the work of the ventricles by decreasing the peripheral resistance. Even if this be the case, the action of the drug in controlling pulmonary hemorrhage is not explained, for it has generally been assumed that the pulmonary capillaries also are dilated. The recent researches of Pic and Pettijean and clinical substantiation of their views as to the use of amyl nitrite in hemoptesis have led Hare (*Lancet*, 1906), who first introduced this treatment, again to direct attention to it. The French observers have shown by experiments on dogs that amyl nitrite strongly contracts the pulmonary vessels, and that the contraction persists for about ten minutes. On the clinical side Hare reports some 34 cases of his own and others, in all but one of which amyl nitrite, in doses of from three to nine minims, promptly controlled the bleeding.—*Editorial Journal Amer. Med. Ass'n.*, Jan. 5, 1907.

Correspondence.

MEDICAL EXAMINERS' FEES.

INVESTIGATION OF MEDICAL COLLEGES.

Camden, N. J., December 21, 1906.

DR. D. C. ENGLISH, *Editor*:

A communication of Dr. Henry Beates, Jr., President of the State Board of Medical Examiners of Pennsylvania, in the *Public Ledger* of Philadelphia, December 20, states that "the failure of 23 per cent. of the doctors who took the examination for licensure this month (December) before the State Board of Medical Examiners proves the crying necessity for an investigation of the actual manner in which the medical college is doing its work and for properly correcting the defects at once."

The State Board of Medical Examiners of New Jersey is confronted by the same conditions as that of Pennsylvania. At the October examinations of the Board, 27 per cent. of applicants approved and admitted to the examination were rejected, and, in addition, six applicants were refused admission to the examination during the year because of insufficient preliminary education. The majority of these applicants were graduates of Philadelphia and Baltimore medical colleges.

New York has steadily raised the curriculum of its medical colleges, as well as its educational standard for licensure through statutory enactments, and the grade of the medical colleges of New York is higher than that of the majority of medical colleges of other states. New Jersey, having no medical college within its borders and no jurisdiction over medical colleges without, has enacted, through the efforts of the profession, educational requirements for licensure equal at least in all respects to those of New York and as high as the science of medicine, at the present time, warrants.

It is doubtful if the educational standards, or methods of instruction, of medical colleges of Philadelphia and Baltimore can be materially advanced by "an investigation of the actual manner in which the medical college is doing its work," as suggested by Dr. Beates. If, however, the medical profession of Pennsylvania and Maryland (in which States the majority of Eastern medical colleges are located) or the medical examining boards of those States should make the educational and examining requirements for state licensure substantially equal to those of New York and New Jersey, especially in the matter of academic education prior to matriculation in a medical college, and should refuse to admit to the examination for state licensure those who can not meet the requirements of their medical statutes, I venture to say that the low standards of medical graduation of which Dr. Beates particularly complains would speedily disappear. Such a union of interest would benefit the profession and protect the public.

In addition, another desirable result would be the eligibility of Pennsylvania and Maryland for reciprocal relations with New York and New Jersey, now denied, and with other States of equal standards.

E. L. B. GODFREY, M. D.

Letter of President W. J. Mayo and Report of the Committee of the American Medical Association.

Rochester, Minn., Nov. 28, 1906.

To the Editor:—I have the honor to transmit herewith the unanimous report of the Committee on Insurance. It will be noted that with a single exception this committee is composed of men who have had the honor of being elected president of the American Medical Association; not one of them makes insurance examinations. Therefore, their action must be looked on at least as disinterested and taken with the sole purpose of guarding the rights and interests of the individual member and upholding the honor and dignity of the profession as a whole. The investigations have lasted for months, including conferences with the officers of the leading companies which inaugurated the changes on which the complaints were based, and have been careful, thorough and impartial.

As the report shows, it is the opinion of all of us that the action of the companies was not only unwise, uncalled-for and unjust, but that the statement that it was made necessary by recent legislative acts in New York is not true. The New York Life, the original sinner in this movement against the profession, reduced the fees eleven years ago, and the Mutual and Equitable followed this bad example long before this legislation was passed.

Attention should be called, incidentally, to the fact that the New York Life Insurance Company has now reduced its fee to \$2.50 in some localities, a reduction so small that it can only be construed as a direct insult to the medical profession. The fact that the Manhattan Company one of the best managed of the New York companies, continues to pay a flat fee of \$5, and informs me that they will continue to do so, is sufficient to refute the statement of the other New York companies. The Phoenix and the Commonwealth companies, which reduced the fee to \$3, are now paying the \$5 rate, and they, too, tell me that they shall continue to pay this rate.

I append a list of companies which pay a flat fee of \$5 and whose officers assure me in recent letters that there is ample margin from their income to continue to do so. All, or nearly all, of these companies do business in New York, and all of them have not only dealt justly with their medical examiners, but have so managed all of their affairs as to escape scandalous charges. I am confident that the fee can be restored if the profession will act unitedly, promptly and conservatively.

Members of the committee were assured that some of the companies would be glad to restore the fee if the profession would unite in requesting it, and, in transmitting the report, I have no hesitation in urging County and State Societies everywhere to take prompt action with this end in view.

We urge, however, that the will of the majority be not made a test of membership, but that kindness, forbearance and moral suasion be substituted for the old spirit of ostracism and exclusion.

W. J. MAYO, *President,*
American Medical Association.

THE REPORT.

To the Medical Profession of the United States:—At the Boston session of the American Medical Association the undersigned were appointed as a committee to investigate and to report on the insurance-examination question. We were instructed to confer with the insurance companies which had reduced the medical examination fee from \$5 to \$3 and, if possible, to induce them to return to the original fee. Nothing could be done during the summer, owing to the fact that representatives of the companies, as well as some members of the committee, were absent on their vacations, either in Europe or at other distant points.

At the earliest opportunity after the vacation the matter was taken up with representatives of the Equitable, the Mutual and the New York Life insurance companies. The last company, it will be remembered, had reduced its fees eleven years ago, and its officers declined at first to meet us in our official capacity. When this technicality was brushed aside it was found that none of these companies would restore the fee unless all should agree to do so. The New York Life Insurance Company apparently blocked the concerted action, essential to a restoration of the fee to \$5, and a compromise proposition, made by us, was also rejected. Therefore, our efforts to influence the companies to restore the fee to a just and proper one have failed.

We were also instructed to make known to the profession, through the Journal or otherwise, the results of the negotiations with the companies, and to advise what policy should be pursued in the event of failure to have the fee restored. In doing this the following facts should be stated:

First—The reduction of fees was made by the companies without consultation with their examiners, either collectively or individually.

Second—The companies insist that they be left to deal with individual physicians and not with the profession as a whole.

Third—On the other hand, they themselves have practically agreed to stand together in maintaining the reduced, insufficient, and, we believe, unjust fee.

Fourth—The companies claim that physicians' fees were reduced on account of the legislation in New York. The facts do not warrant this statement. The fee was reduced by the New York Life eleven years before the present law in New York was thought of, and by the others before it was proposed. The recent action of the Manhattan, a New York company, restoring the fee to \$5, only emphasizes the correctness of our position on this point.

Fifth—We find that the so-called economic measures instituted by these insurance companies have apparently been chiefly in the medical department, and that the medical department was almost the only one which was not smirched by the past history of extravagance practiced by the officers of the companies.

Sixth—We believe that the companies can and should continue to pay a minimum fee of \$5 for medical examinations, which seems to us to be a reasonable and just remuneration.

These are the facts, and we refer the question to the County and State Societies for such action as they may deem wise and proper. We urge, however, that the will of the majority be not made a test of membership, in accordance with the modern idea in the profession that kindness

and moral suasion should be substituted for the old methods of ostracism and exclusion in all work.—J. H. Musser, Chairman; John A. Wyeth, Wm. J. Mayo, Frank Billings, J. N. McCormack.

BOARD OF HEALTH OF THE STATE OF NEW JERSEY.

Monthly Statement—December, 1906.

The number of deaths reported to the Bureau of Vital Statistics for the month of December, 1906, was 2,270, a decrease of 193 from the previous month, this being a lower number of deaths than for any similar period during the last six months. By ages there were 428 deaths among infants under one year, 184 deaths of children over one year and under five years, and 671 deaths of persons aged sixty years and over. Pneumonia and diseases of the respiratory system show the highest death rate. The number of deaths from pneumonia for the month of December was 227. Pulmonary tuberculosis caused 248 deaths, an increase of 14 over the previous month. The number of deaths from typhoid fever is less than usual at this period of the year, the number of deaths for December from this disease being 47, a decrease of 6 from the previous month. There has been a notable decrease of deaths from diseases of the nervous system during the past six months. The figures are as follows: July, 382; August, 370; September, 317; October, 313; November, 306; December, 291.

The following table shows the number of certificates of death received in the State Bureau of Vital Statistics during the month of December, 1906, and also the number of deaths from certain selected causes.

CAUSES OF DEATH AND NUMBER OF CERTIFICATES RECEIVED.

Typhoid fever, 47; measles, 2; scarlet fever, 7; whooping cough, 21; diphtheria and croup, 68; malarial fever, 3; tuberculosis of lungs, 248; tuberculosis of other organs, 47; cancer, 94; cerebral spinal meningitis, 17; diseases of nervous system, 291; diseases of circulatory system, 243; diseases of respiratory system, (pneumonia excepted), 151; pneumonia, 227; infantile diarrhoea, 79; diseases of digestive system, (infantile diarrhoea excepted), 119; Bright's disease, 159; suicide, 20; all other causes, 427. Total, 2270.

Food and Drugs—During the month of December, 1906, 322 specimens were examined under the direction of the State Board of Health, in the State Laboratory of Hygiene, as follows:

Articles examined.	Number of specimens standard	Number above standard	Number below standard	Percentage adulterated
Milk	189	172	17	8.9
Butter	17	15	2	11.7
Cream	4	4	0	0.0
Honey	2	2	0	0.0
Molasses	12	12	0	0.0
Olive oil ..	6	6	0	0.0
Syrup	3	3	0	0.0
Vinegar, cider...	26	15	11	42.3
Vinegar, white...	1	0	1	100.0
Borax	10	10	0	0.0
Camphorated oil.	5	3	2	40.0
Cream Tartar...	22	22	0	0.0
Tincture aconite	1	0	1	100.0
Tincture iodine...	10	3	7	70.0
Tincture opium...	6	0	6	100.0
	314	267	47	14.9

Number of samples of water analyzed, 8.

Bacteriological Examination for Diagnosis.

—During the month of December 716 specimens were examined for diagnosis, as follows: From suspected cases of diphtheria, 344; tuberculosis, 229; typhoid fever, 129; malaria, 8; miscellaneous, 6.

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A PLEA FOR THE USE OF UNITED STATES PHARMACOPEIA AND STANDARD PHARMACEUTICALS VS. PROPRIETARIES.*

By Henry H. Sherk, M. D., Camden.

In selecting the subject chosen for this paper, the writer is not unmindful of the many papers preceding it, some of which have been extremely valuable to our profession.

He feels, however, that the subject is of such importance that a repetition will not be out of order, and at the risk of tiring his hearers he will add his mite to the store already contributed. The good work done by Dr. Frank Billings, of Chicago and others, the Council of Pharmacy and Chemistry of the American Medical Association, ably assisted by the various State journals, cannot be over-estimated. They have done much to awaken from their lethargy the members of the medical profession and to make us see the importance of studying Pharmacopeia, with its vast store of knowledge: containing, as it does, our best medical thought in its particular province. Why a number of physicians should in their daily work prescribe remedies which have nothing to recommend them but the boasting of their owners is hard to comprehend, unless it is because of their lack of knowledge of the many excellent preparations, the formulae of which are found printed in the pages of the Pharmacopeia, the National Formulary

and our Dispensatories. One is led to believe that there exists in these pages a remedy suitable for almost all diseased conditions. Then why run after strange gods and prescribe preparations of whose therapeutic value we know little or nothing, and which are recommended only by some oily-tongued detail man who knows it all, and who would inform us that we cannot practice medicine without his special concoction!

Are not the official preparations and those in the various works of pharmacy and materia medica of such value that we should make use of them to the exclusion of others, especially the so-called proprietaries? In order to accomplish even limited success in our work, the most essential step is to accept the Pharmacopeia together with the works just mentioned as our standards. It may be necessary to call attention to some of the important changes that have been made in the new edition of the Pharmacopeia. The tinctures are uniformly 10 and 20 per cent. in strength, and for the first time, poisonous galenicals will conform to the standard of the international Pharmacopeias. The average dose is given and has been approved of by all the physicians on the committee. Changes in official titles are numerous as well as change in spelling. Fluid-extract is one word instead of two. Hydroxide takes the place of Hydrate, it is now Acetanilide, the final e being added.

A number of synthetical chemicals are admitted under an abbreviated form of their long chemical names (only after their real value has been demonstrated by repeated and long-continued trials by many practitioners. The list of reagents has been enlarged, some, which have been found unsatisfactory, have been replaced by others,

* Read at the 140th Annual Meeting of the Medical Society of New Jersey.

(as in the case of the arsenic test) and the tables of elements and the principal Pharmacopeial chemicals have been revised to correspond with the figures of the elements adopted by the international committee on atomic weights. The degree of purity for each substance is definitely stated whenever possible, and takes the form of a minimum requirement which enables one at a glance, to ascertain the quantity in each specific case. The subjects have also been systematized. The work of revision has been very thoroughly performed, no detail having been too small for full consideration, and no aspect of pharmacy which might be affected by pharmacopeal standard neglected. Yet there is an air of conservatism about the Pharmacopeia which suggests that the compilers have exercised great care and caution in their work.

At a meeting held March 11, 1906, in the College of Physicians, in Philadelphia, the formation of a national Association to fight the patent medicine evil and all forms of irregular practice was urged. Dr. Henry Beates declared that the Pennsylvania Medical Laws were so futile that prosecution cannot be successfully carried out in the courts. State Health Com. Dixon said he had been assured by the Governor and various members of the Legislature that a law would be enacted for the revocation of license by the State Board of Medical Examiners where just cause is shown, and also to forbid the sale of patent medicines unless a detailed formula is printed on the bottle. Another meeting held on February 21st of this year by the members of the Civic Club, was addressed by Doctors Gohlin and Coplin, who claimed that the majority of nostrums so widely advertised are poisonous and, as we all know, contain certain large percentages of alcohol. Cases of alcoholism were not infrequent when the victim did not understand the use of them. In the New York Medical Journal Dr. Billings states that there is no other country, with one or two exceptions, where this menace to the welfare of the people and the best interests of scientific medicine has developed as it has in the United States. The reason can probably be found in the fact that other countries protect their people against frauds in foods, medicines, etc. It is to be hoped that Congress will soon enact laws which shall include the regulation of proprietary and other medicines. However, to those physicians who prescribe scientifically, the mixtures foisted on the market are objectionable even though the printed for-

mula is given. Diseased conditions are not always the same in different patients, hence the treatment must be modified to meet the various conditions as they arise; and he who prescribes intelligently will not use the made up mixtures that are advertised in numerous journals as sure cures for the thousand and one ills flesh is heir to.

If these things be true of those preparations of a known formula, what must be said of those compounds of a semi-secret nature? Against the use of such preparations the profession should boldly contend. The advertisement of proprietary medicines in medical journals has occupied the attention of the American Medical Association and has led to the adoption of the following rules: Articles to be refused on publication:

First: Articles for internal medical use advertised or in any way exploited as remedies or cures. Many articles of this group have received medical favor only to be exploited to the public. Is the physician not doing himself an unpardonable injury by prescribing this class of remedies? In most cases the name blown on the bottle gives his patient an idea (which he only too eagerly seizes) and the next time he wants the medicine, gets it at the druggists's instead of consulting his physician; thus taking from the doctor his rightful fee and making richer some manufacturer who cares little or nothing for the man who made possible his wealth. "What fools we mortals be."

Another class of the so-called ethical preparations are those whose formulae are deceptive, or in other words, misleading. Here is a prominent advertisement which appears in one of the Medical Journals, which claims it does not advertise nostrums. "Relieves valvular heart trouble, reducing the number of heart beats, giving the heart a rest. Increases the force of the systole, causing the valves to close more thoroughly, thus preventing regurgitation, relieving dyspnoea and increasing heart nutrition. Cirrhosis of the Liver: By equalizing the circulation, dilating the arterioles, thus relieving the obstruction of the branches of the hepatic artery and portal radicals, securing better circulation of the liver, and more nutrition to the cells, and interlobular connective tissue. Bright's Disease: By its power to relieve distal engorgement, through its wonderful equalizing effect on the circulation, dilating the arterioles and establishing a normal physiological balance between the arterial and venous system."

The proprietors of this wonderful medicine claim to give the formula which is

printed on an inclosed circular, and it is said to be composed of the following ingredients: *Oxydendron Arboreum* (Sour Wood); *Sambucus Canadensis* (Elder Blossoms); *Urgena Scillae* (Squills). The first drug is not recognized in the Dispensatory, and as far as can be ascertained has very feeble therapeutic action. Every grandmother knows all about the second. The third is not given under its true official name. Any physician knows that a combination of these simple drugs will not produce the therapeutic action claimed. This package contains sixty-five tablets, for which the consumer pays the enormous price of two dollars.

Still another bane to the physician as well as to the pharmacist is the use of arbitrarily selected names—so-called copyright names. They have multiplied to such an extent as to cause utter confusion. Physicians, like others in these strenuous times, desire to save time and have thus fallen into the trap of convenience. While in the beginning the custom presented no great objection, it has now assumed a serious phase. One cannot enumerate the many examples of these almost similar preparations, but over two thousand German synthetics alone, the system of nomenclature has almost become a nightmare to those who try to keep up with modern therapeutics. The following is a copy of a letter sent by the writer to a number of pharmacists with a view of getting an accurate opinion as to the number of proprietary articles prescribed by physicians.

"Dear Sir:—Would you kindly inform me to what extent is the ratio of prescriptions received for compounding,—first, for official drugs and those recognized as regular pharmaceuticals; second, those recognized as proprietary medicines?"

The following answer is from one of the most prominent pharmacists in Philadelphia, who says: "I believe at least 25 per cent. of our prescriptions are for distinctly proprietary articles. I should say at least 60 per cent. of our prescriptions contain proprietary articles in combination with pharmaceuticals, and about 25 per cent. are for Pharmacopeal and pharmaceutical preparations. The proportions of proprietary articles is becoming greater every year. I suppose the younger generation of physicians are not properly educated in prescription writing, or they are so ignorant of therapeutics that they are unable to prescribe regular medicines, and so come to rely on what manufacturing agents tell them.

It is easier to write *Antikamnia* than *Pulv. Acetanilide Comp.*"

The following interesting letter was received, showing the yearly increase of proprietary remedies prescribed by physicians: "We selected the first twenty-five prescriptions in the months of January, April, July, and October, in the following years, and find the percentage of prescriptions containing one or more proprietary preparations as follows, 1898—18 per cent.; 1899—24 per cent.; 1900—25 per cent.; 1901—23 per cent.; 1902—29 per cent.; 1903—29 per cent.; 1904—32 per cent.; 1905—34 per cent.

Another prominent druggist says: "In reply to your would state that we started with prescriptions for that day and went back one thousand with the following result. Numbers show a total of 167 different physicians. Legitimate prescriptions calling for standard ingredients, 698; straight out-and-out proprietaries, 79; make specified, 21; Prescriptions calling for proprietaries as one or more ingredients, 61; prescriptions calling for trade mark names, 105; prescriptions calling for ingredients with make specified, 33."

Here is one from another of the most prominent pharmacists in New Jersey, taken from one thousand prescriptions prescribed to a recent date. "I submit the figures as per your request: Number of prescriptions for proprietaries only, 148, number for proprietaries in part 178; number for regular pharmaceuticals, 707. The percentage being as follows: proprietaries only, 14 per cent.; proprietaries in part, 17 per cent.; regular pharmaceuticals, 68 per cent. Many of the first two classes called for as many as three or four proprietaries in the same prescription."

The President of the American Pharmaceutical Association writes as follows: "I believe when you have statistics such as you seek, you will be surprised how many of your professional brethren are perfectly satisfied to have some one else think for them and formulate prescriptions and preparations, that they in turn will give a case laid upon their conscience. In my experience the number of straight out proprietaries is about 16 per cent."

Five hundred prescriptions as examined in two of Philadelphia's foremost drug-stores by Dr. W. C. Thrush, furnish some interesting data. These prescriptions were from leading physicians of that city, and some were members of the faculties of medical schools, hence represent the type of

prescription writing of our best practitioners. Out of one thousand prescriptions, 718 contain 2 to 5 ingredients; 232 only one drug; 485 official preparations only; 359 proprietary preparations in whole or in part.

Defective knowledge of prescription writing is most noticeable among recent graduates. This points to a deficient training in this most important branch, even in our best medical schools. May not this unfamiliarity with drugs partially account for the increasing tendency to prescribe proprietaries instead of official and regular pharmaceuticals? In studying these tables one will find that an average of 29 per cent. of prescriptions compounded by pharmacists are of a proprietary nature. The amount of proprietaries dispensed by physicians themselves in their offices cannot be estimated, but the percentage must be much larger.

One thing the physician owes to his patients, especially to the poorer ones, is to lessen the cost of medicines as much as possible. This can be done in a great measure in prescribing from the United States Pharmacopeia and using regular pharmaceuticals in lieu of the expensive and, in some cases, worthless preparations. Let us study our Pharmacopeia and allied works on Pharmacy and Materia Medica. Let us restrict ourselves to the use, as much as possible, of remedies whose therapeutic and physiological action we can know all about by research and study. Then we will practice our profession more scientifically and intelligently, and save ourselves the onus of making rich a class of persons who care little or nothing for suffering humanity, but whose sole desire is to put gold into their coffers at the expense of a lot of gullible physicians.

During the month of March there appeared an advertisement in one of the Philadelphia daily papers, a list of over one hundred proprietary preparations offered for sale to the public. Each of these preparations was first introduced to the profession as strictly ethical, and after a demand was created for them, mainly through the influence of physicians, they were given to the public at cut-rate prices, something like the following: Gude's Peptomangan, 87 cents, Fellows' Hypophosphites, 80 cents; Listerine, 75 cents, and so on ad libitum.

How long will we, as purveyors to the health of the public, suffer this evil to survive? Without our aid these articles could never have gained a foot-hold on the market. The remedy is to eschew evil and hold

fast to that which is good. Let us encourage the pharmacist to excel in manufacturing the class of preparations we can dispense on our own prescriptions, or in other words, let us do our own thinking.

Following is a list of proprietary names for a list of official preparations:

Official Preparations:	U. S. P. Names.
Erotropin }	Hexamethylenetetramine
Formin }	
Cystogen }	
Lysterine }	Liquor Antisepticus
Borolyptol }	
Lysol	Syrupus cresolis comp.
Fellows Syrup of the Hypophosphites	Syrupus hypophosphit. comp.
Formalin	Liquor formaldehydi
Cosmoline }	Petrolatum
Abolin }	
Vaseline	Petrolatum alba
Liquid aboline }	Petrolatum liquidum.
Liquid vaseline }	
Antikamnia	Pulvis acetanilidi comp.
Sulphonal	Sulphomethanum
Trional	Sulphomethylmamine
Aristol	Thymolis iodidum
Vin mariani, etc.	Vin coca
Urethan	Ethyl carbamas
Phenacetine	Acetphenetidum
Lanolin saccharin	Adeps lannae
Guarrantose	Benzosulphidum
Sugar chystol	
Duatol	Guaiacolis carbonas
Dermatol	Bismuth subgallas.
Antiphlogistine	
Creta methyl	Cataplasma Kaolini
Glyco terraetc, etc.	
Chloralamide	Chloralformamidum
Maltine, Maltzyme, etc.	Extractum malti.
Elixir Lactopeptine	Elixir degestivum
	Elixir lactated pepsin
Gray's Glycerine Tonic	Elixir gentian
Arsenauro	Liquor auri et arsenici, bromidi
Lactopeptine powder	Pulvis pepsini comp.
Havden's virburnum compound	Tincture viburnum opuli comp.

The prices of these preparations are in nearly all cases much lower than the proprietaries, hence the great advantage to both physician and patient to prescribe these remedies and stick to legitimate pharmacy as well as legitimate medicine. In the language of professor Hare, "Remember, that

the good physician is one who, having pure drugs, knows when to use them, and, being equally important, when not to use them."

DISCUSSION.

Dr. Fred Miller Corwin, of Bayonne.—Not to go into detail, I want to say that the reasons for the great success of the manufacturing pharmacists in pushing their preparations on the profession are based on a lack of fundamental knowledge, on our part, of drugs, and on the credulity of a certain part of us in seeking after the mysterious, and things not well understood. Two articles of mine, on this subject, have appeared in our JOURNAL, and some of you may have seen them; they go over the subject in much more detail than I can now.

This matter of credulity is well illustrated in the reports we have just heard about the influence of antitoxins in the treatment of chorea. One man used diphtheria antitoxin, and claims to have had good results; another man used the antitetanic serum, and he claims good results; etc., etc. Now when you inject an antitoxin into a child, you hurt that child; you make a powerful irritation and cause a powerful shock to its nervous system, which perhaps may produce an effect on some cases of chorea, and it is quite probable that an injection of normal saline solution would do the same thing in the same case, but there is the credulity in the profession that the manufacturer wants to work on. Ten years ago we did not use antitoxins for everything, and we have no call to do so to-day. I do not wish to convey the impression that I do not use diphtheria antitoxin when I find what I consider the proper indications for it, but I take pleasure in saying that I do not use it one-tenth as often as the manufacturers would like to make me believe I ought to use it.

TWO CASES OF EXTRA-UTERINE PREGNANCY OCCURRING IN THE SAME INDIVIDUAL AT FIVE MONTHS INTERVAL.

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County Hospital and St.
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There is no calamity affecting the domestic circle which is so appalling in its suddenness and so overwhelming in its results as a ruptured extra-uterine pregnancy. The writer has known a young bride of less than two months to faint and die before assistance could be summoned, as a result of this accident. This was many years ago, when the premonitory symptoms of the condition

were not as generally recognized as at the present day. In another recent case occurring in the practice of the writer, the husband left his wife apparently in perfect health, except for a few colicky pains during the night, four hours later to meet her in the hospital, saved by a hair's breadth from death after an abdominal section undertaken with the patient in extremis. Such cases are relatively quite common, at least in our large cities. So sudden are the symptoms that they have sometimes been mistaken for those occasioned by poison, on account of the severe abdominal pain and the rapid collapse.

Thus a French princess, daughter of Charles I of England died with all the symptoms of a ruptured ectopic gestation, the onset of the symptoms occurring immediately after drinking part of a glass of water. She died in a few hours with classical symptoms. One of her ladies in waiting drank the remainder of the glass of water without evil effects. For a long time the English nation believed that she had been poisoned.

In a still later case, a celebrated English actress died suddenly in a restaurant in Paris, and it was supposed and currently stated that she died from poison until the autopsy disclosed the true condition—a ruptured ectopic gestation. Von Neugebauer has recently reported a somewhat similar case in which a trained observer like himself suspected that the death of the patient was due to acute ptomaine poisoning. This case is of sufficient interest to give in detail, particularly as illustrating the suddenness of the catastrophe and the fact that the preliminary symptoms are not always to be counted upon. Von Neugebauer states that there had been a normal pregnancy four years prior to the accident; that four months before the acute symptoms appeared, the lady had consulted him to know why she did not again become pregnant as she wished for a son; V. Neugebauer thereupon discovering an ectropion of the cervical membrane, treated it with the actual cautery, after which she became pregnant. Between the eighth and tenth week she was suddenly taken ill on her return from a ball with vomiting, diarrhoea and strangury. The reporter saw her three and a half hours later. She was then pulseless, icy cold, and the pain in her abdomen caused her to scream violently. Poisoning was thought of as she had eaten of mayonnaise and fish for supper. She failed to respond to stimulation and died half an hour after the

*Read before the Tri-County Medical Society of the Counties of Morris, Warren and Sussex, Oct. 1906.

arrival of V. Neugebauer. The autopsy disclosed a normal pregnancy and a coincident extra-uterine pregnancy of the right tube with a small rent on its anterior surface. The abdomen was filled with clots and fluid blood. With records like that before us it is evident that we cannot be too familiar with the premonitory symptoms which should put us on our guard and look with great suspicion on all cases of acute abdominal pain in women of the child-bearing age, especially when associated with collapse. The condition is one which the profession has been slow to recognize. When the writer was a medical student, thirty years ago, he used to hear a great deal about pelvic hematocele, but little if anything about extra-uterine pregnancies, which in fact were then almost universally called pelvic hematoceles.

Kelly states that the first recorded operation for the relief of the condition prior to the rupture was performed by him in 1886, only twenty years ago. As a rule, the premonitory symptoms are quite clear, and should at once put the physician on his guard so that he will make the necessary vaginal examination which will reveal the true condition. Cases of recurring pregnancies in the same tube where the condition has been treated without the removal of the offending tube are not very uncommon, and traces of previous abnormal pregnancies have been discovered in the course of an operation for rupture. A case of the writer's operated in January and June of the current year is so unusual however, because of the short interval elapsing between the two pregnancies that it is thought worthy of report to this society with some remarks on the general subject. The case is as follows: The writer was called up on the telephone by Dr. Hegeman, of Brooklyn, who said that he was sending into St. John's Hospital for immediate operation a case of ruptured extra-uterine pregnancy. From him I received the following history. "The patient, Mrs. R., 25 years of age, consulted me late in December, 1905, because of irregularity of menses. Normal menstruation had occurred in October and a slight flow in November, lasting about a day. During the first week in December she began to flow again, losing a moderate amount of dark colored blood which after a few days became an intermittent dribble, continuing until the 24th, when she presented herself at my office. She refused to allow me to make a vaginal examination and requested me to prescribe for her, saying she wanted

the flow stopped. On December 31st I was called to her house and found her more amenable to reason. She was suffering much pain and told me that she had experienced her first pain on December 18th, which was cramp-like in its character and lasted about five hours. Since then she has had short, cramping pains every second or third day, but there was always a dull, aching pain in the right inguinal region made worse on defecation and deep inspiration. She also had some chills with fever. Vaginal examination revealed the uterus in normal position, somewhat larger than normal and high up and to the right of the fundus, a mass which was moderately tender on pressure, without fluctuation and about the size of an egg. A diagnosis of right tubal pregnancy was made and immediate operation advised but declined. Four days later following another attack of pain, she accepted operation and was transferred to St. John's Hospital." The patient now came under care of the writer, and examination revealing exactly the condition reported by the family physician, she was prepared for operation and the abdomen promptly opened. A right tubal pregnancy was discovered which had been ruptured into the broad ligament, constituting the somewhat rare condition known as intraligamentous rupture. The tube and ovary of that side were removed and the abdomen closed without drainage. The patient made a prompt recovery and left the hospital three weeks afterward. She continued in good health for two months, her menstrual periods being regular and lasting for two days, but in April she skipped her period, and May 2nd commenced to have a light bloody colored discharge about every other day, increasing in depth of color progressively. About the end of the month (on getting up suddenly) she passed a solid irregular mass about as large as a lemon. On June 6th she called at Dr. Hegeman's office, complaining then of dribbling flow and constant pain over bladder and at McBurney's point, temperature and pulse, however, normal. Vaginal examination disclosed a uterus which seemed to be irregularly enlarged—at the fundus more particularly. Dr. Hegeman considered the mass too large for a fibroid of a few month's growth, as the uterus was free from any such growth in January. He suggested to the patient the possibility of a second ectopic pregnancy and advised exploration, but she declined. Four days later she had an attack of severe lancinating pain,

and consenting to interference, was transferred to St. John's Hospital, the writer notified, and a second operation done. A pregnancy of the left tube close to the cornu was discovered. The mass was about the size of a pigeon's egg. The tube was flexed upon itself and was much adherent to the uterus. A rupture had occurred in the tube itself, but there was no intraperitoneal hemorrhage. The tube was removed, but not the ovary, the abdomen being closed without drain. The recovery was uneventful and the patient returned to her home within three weeks.

Cases of recurrences of tubal gestation are not rare. Not a few have been reported as occurring in the same tube where this has been treated with conservatism—without removal. A number of cases of recurrent tubal pregnancy in the opposite tube have also been recorded. Indeed, H. Haultain (*British Journal of Obstetrics and Gynecology*) remarks that one of the most striking results of his experience in 23 cases was the frequency of recurrence. The writer has not, however, been able to find an earlier recurrence than that reported. Haultain had one within nine months, whereas the present case occurred within five months, and it is difficult to see how recurrence could take place much earlier. Apart from this, the case has been thought worth reporting, since all the classical symptoms, both subjective and objective of this pathological condition were present to aid the observer in making a diagnosis. This is not always the case, as the symptoms are not infrequently irregular. Thus in Haultain's series of 23 cases, amenorrhoea was absent in 5 cases, irregular hemorrhage in 4, pelvic pain or discomfort in 4 and the shedding of decidua in 16. In the present case, however, there was first amenorrhoea. This symptom by itself, occurring in a married woman is of little if any importance. It is only when an amenorrhoea of one or two months is followed by irregular hemorrhages that it becomes of importance and should imperatively demand a pelvic examination even in the absence of pain. The color of the discharge is characteristic. It is dark, sometimes almost black, and is persistent. This persistence of discharge is well illustrated in the present case, since it was the symptom which first led the patient to seek advice. It is also common for the hemorrhage to cease for a day or two at a time as it did in this case, and then to recur. This patient passed a decidua in her second extra-

uterine pregnancy, but there is no record of a similar occurrence the first time. This symptom is more frequently absent than any other. In a doubtful case, where shreds of tissue have been passed, the microscope will reveal the presence of decidua which should at once apprise the attendant of the true condition. With regard to pain, the history of this patient may be regarded as giving a perfectly classical picture; the acute attacks varying in severity, followed by a dull and more or less constant ache. The pain is not always referred to the side involved. It may be in the back, in the lower abdomen or on either side. It not infrequently follows the course of the sciatic nerve down the leg. Micturition and defecation are also usually painful. When a woman of the child-bearing age presents herself with symptoms of irregular hemorrhage and cramp-like colicky abdominal pains, whether there be a history of amenorrhoea or not, she should be subjected to a most careful pelvic examination, and refusing this the attendant would be justified in declining to be responsible for further treatment. What will be found as a result of such examination? First, an enlarged uterus. Softening of the cervix (Hegar's sign) is not as marked as in normal pregnancies, but the uterine enlargement is constant though not to the extent which would be expected in a normal pregnancy. In any but the earliest cases a tumor which is distinct from the uterus on one side or the other, frequently in the cul de sac may be palpated by the examining finger. This will be almost always tender. In fact, I never have seen but one exception to the presence of tenderness. That was in the case of a young nullipara, the wife of a physician, whose only symptoms had been some slight colicky pains and irregular menstruation. In this case there was absolutely no vaginal tenderness and no palpable tumor. The surgeon with whom I saw the case in consultation, operated the following day, his opinion coinciding with mine, and removed an unruptured left tubal pregnancy the size of a chestnut.

Some writers advise the passage of the uterine sound on the ground that this will afford definite proof of the condition of the uterus, as to whether there is an enlargement, and as to whether it is empty or not. The writer desires to enter his emphatic protest against such procedure. The physician who cannot determine an enlargement of the uterus under circum-

stances, such as to justify the suspicion of an extra-uterine pregnancy without the use of the sound, has mistaken his vocation. Certainly its use to determine whether there is an uterine pregnancy, will, I am sure, commend itself to no one here. An important point which should not be neglected is to observe the utmost gentleness in making the vaginal examination, lest a rupture be produced or an existing hemorrhage aggravated. Where an intra-peritoneal rupture has occurred, the subjective symptoms will usually be very severe, the pain will be excessive and the hemorrhage great. Thus, unless the bleeding vessel is promptly secured, the patient will quickly succumb. It has been stated that occasionally the symptoms produced by an intraperitoneal rupture may be slight. This has not, however, been the experience of the writer. As, however, the statement has been made by competent authority, it ought to find place here. It is to be remembered that a tubal pregnancy may rupture in three ways; into the tube itself, the blood escaping into the peritoneum by the fimbriated extremity, if the hemorrhage is of sufficient extent. This is the so-called tubal abortion. Again the tube may rupture downward into the broad ligament, in which case the blood dissects its way between the two layers of peritoneum and infiltrates the connective tissue. This is the rarest form of rupture. Finally, rupture may take place directly through the walls of the tube into the peritoneal cavity. This is the most dangerous variety. It is astonishing to witness the massive hemorrhages which may quickly occur as a result of a tiny rupture of this sort. Von Neugebauer states that the rupture in the case previously cited was less than a quarter of an inch long.

Haultain cites a case of his own in which the woman was rendered pulseless in less than five hours by bleeding from a ruptured ectopic less in size than a pea. It should be remembered, however, that the vessels which are concerned in the bleeding are not exposed to the air and have no tendency to contract and close the bleeding points as in the case of surface hemorrhage. It is not of great importance to be able to make a diagnosis between the different forms of rupture, as they all call for swift operation. In the intraperitoneal form, there is apt to be a fall in temperature following the hemorrhage, whereas when the bleeding comes from the ostium the symptoms are less acute and there is a rise in temperature. With regard to the temperature, it may be stated

that except in the collapse which follows severe bleeding, there is almost always subsequent elevation of temperature, due probably, to peritoneal irritation and the absorption of fibrin ferment. There are a number of conditions which may resemble a ruptured extrauterine pregnancy. The writer has twice seen a ruptured pyo-salpinx give rise to collapse, acute pain, which together with the presence of a tender tumor on vaginal examination and some previous regularity, justified the belief that we were dealing with an ectopic pregnancy. Acute appendicitis is sometimes confusing, particularly where the attack is sudden and the appendix points downward in the direction of the uterus. In the extra-uterine pregnancy, however, there is absent any sign of muscular rigidity which is so common in the inflammatory condition. Also collapse is apt to be present where there has been much hemorrhage, which is not usually present in acute appendicitis.

A number of other acute abdominal conditions will give rise to collapse and severe abdominal pain, such as perforation of a duodenal ulcer, acute hemorrhagic pancreatitis, but in these cases the pain is higher up, the tenderness is in the epigastrium and there is no pelvic tumor or tenderness. The previous history, if carefully taken, will also prevent error. After all the differential diagnosis is not of such great practical importance, because if a woman has symptoms of severe abdominal pain, tenderness and collapse, these in themselves call for explorative laparotomy. The following case will illustrate what is likely to be the most common mistake in dealing with this condition. A woman was admitted into a neighboring hospital with a history of amenorrhoea of six week's duration, then pain, the expulsion of a small mass and subsequent obstinate hemorrhage. She stated to the physician who was called in, that she had miscarried. She was accordingly given an anaesthetic and curried, whereupon, while still on the table, the patient went into collapse. The abdomen was promptly opened, a ruptured gestation sac disclosed which was removed, and the patient promptly recovered. Here the passage of the decidua was mistaken for the products of a uterine conception. It is possible that a careful vaginal examination would have revealed the presence of a tender tumor, and careful questioning would have cleared up the case.

It is more difficult to distinguish between other causes of error in those cases in which

an unruptured extra-uterine gestation is suspected, and of much greater importance not to make an error and subject the patient to a needless operation. The following case which came under the observation of the writer will illustrate one of the conditions which is likely to cause perplexity. He was called in consultation to see a young married woman, a nullipara who had missed one period. She had called upon her physician who had previously treated her for dysmenorrhoea and asked him to examine her and see whether she was pregnant. The examination showed an enlarged uterus and a small elastic tumor in the right tube. The writer found the same condition. The tumor was not tender, however. On this account, the writer suggested the possibility of a small cyst with a coincident uterine pregnancy. In view of the dangerous possibilities of the case, it was advised, however, that the patient be admitted to the hospital for observation, and quick operation if necessary. The family thereupon requested that a second consultant, a friend of the husband, be called in. After he had examined the case he came to the conclusion that there was an ectopic gestation present, removed the lady to his private hospital and the following morning removed a small unilocular ovarian cyst, the tumor in question. The uterine pregnancy went on to term. In reference to this case one may reasonably observe that it was better to remove a cyst, in itself certain to grow, than to run the risk of allowing a possible gestation sac to go on to rupture and possibly kill the patient. A cornual pregnancy is sometimes very difficult to diagnose from an extra-uterine in the tube close to the cornu. Close observation in a hospital is the only safeguard in such a condition.

What is the proper treatment of extra-uterine pregnancy? There can be little room for argument or controversy on this question. When unruptured, it is to be regarded, as some writers have expressed it, as a malignant condition to be removed as soon as possible. When we realize the suddenness of the symptoms of rupture, the very rapid hemorrhage, there seems to be no reason, when the diagnosis has once been established, why the operation should not be immediate. Before rupture the work may be undertaken, relatively, at leisure. If we wait until rupture has taken place we may have to deal with an abdomen full of clots and an exsanguinated patient. There are one or two points which are worthy of

mention with reference to details of treatment after rupture has taken place. It is folly to wait for the patient to come out of her collapse, to administer stimulants—strychnine or adrenalin with the view of improving the pulse, while bleeding is still continuing unchecked. The use of the saline infusion is particularly to be deprecated prior to the operation. Nature's only defence against such hemorrhage is syncope. Anything which raises the blood pressure before the bleeding point is tied simply increases the loss of blood. There is but one indication in these cases of rupture, and that is to open the abdomen with all speed, find the uterus, identify the affected side and then put clamps on the uterine and pelvic side of the sac. The hemorrhage is now controlled, and now, and not until after this has been done, is it wise to do anything to raise the blood pressure. A recent case will serve to illustrate. The writer was called up in the spring by Dr. Hegeman and informed that he was sending to St. John's Hospital, for immediate operation, a case of ruptured extra-uterine gestation. The symptoms had not previously been of sufficient severity to cause the woman to seek advice. Her husband had left her in the morning in her usual health. She was seized with a sudden severe pain in the abdomen, together with extreme faintness and summoned Dr. Hegeman, who at once sent her to the hospital. The writer arrived there at the same time and confirmed the diagnosis by a rapid examination, sent the woman, who was almost pulseless, to the operating room. The preparation was most hasty. There was no time for an elaborate toilet. Two members of the house staff were detailed to open the medium basilic vein while the abdominal work was being done, but they were directed on no account to introduce the saline solution until the bleeding pelvic vessels were secured. The patient being slightly anaesthetized, the abdomen was opened and found to be filled with clots and fluid blood. No attempt was made to clear out the clots, but the uterus was immediately seized, the bleeding found to come from a ruptured gestation sac on the left tube. With good fortune, the two clamps controlling the circulation were placed in two minutes after the first incision. But by this time, rapid as had been the work, the patient was gasping and apparently dying. Hot saline, of a temperature of 120, was now allowed to flow into the vein and the affected tube was removed, the work up to this time occupying

just four minutes. The breathing now apparently became deep as the saline infusion increased the blood pressure. All ligatures having been placed, the blood clots and fluid blood were mopped out of the peritoneal cavity and the wound closed without a drain. The patient made a good recovery, nor did any infection occur in the wound in spite of the hasty preparation of patient and operator.

To sum up, cases of extra-uterine pregnancy are usually characterized by the following symptoms grouped in the order of their frequency: before rupture, subjective, *pain*, abdominal and pelvic, cramp-like in character; *irregular hemorrhage*, *amenorrhoea* of variable duration; the expulsion of a decidua (very frequently absent). Objective (upon examination): a tender tumor mass in the pelvis with an enlarged uterus; if bleeding has taken place to any extent, a boggy feeling in the cul de sac. After rupture, if intraperitoneal, violent pain, syncope, rapid collapse, fall in temperature, abdominal tenderness. If extra-peritoneal, rise of temperature, pain less severe, collapse not usual.

The treatment of the condition is exactly that which is done for arterial hemorrhage on the surface of the body, immediate control of the vessel by ligation.

TUBERCULOSIS.*

By G. K. Dickinson, M. D.,
Jersey City, N. J.

The history of the fight for life has developed the peculiar fact that man's natural enemies are gradually diminishing in size. The mammoth is extinct; the larger animals of the past have been relegated, and now, the greatest menace to life lies in a little microbe not more than one ten-thousandth of an inch long. Small though its size, great is its ability for propagation. The presence of this germ is the cause of more deaths yearly than all other infectious diseases. Although it is believed that not more than two-thirds of the cases of consumption in New York are reported, nevertheless, some nine thousand cases were recorded in the year 1900. In England and Wales sixty thousand people die annually from this disease. No wonder is it that communities are alive to the need of its sup-

pression, and a greater wonder is it that the Boards of Health as a unit do not exert their full influence to the suppression of the same. By a battle against tuberculosis more good could be done, more lives saved, and misery and poverty minimized, than by licensing plumbers and disinfecting after infectious diseases in childhood. It is not as though we did not know its cause, as in the case of scarlet fever, but we have accurate knowledge of the same and of the conditions attending its propagation. This disease is due to a germ. We know its life history. It is born in the sputum. It is thrown out with the sputum. It is disseminated from the individual. It has been calculated that one consumptive may produce daily seven thousand two hundred millions of bacilli, from which it is obvious that if he be careless or ignorant and permits his expectorations to dry, he may be an ever present source of danger. In ordinary respiration no bacilli are thrown out by the expiration of air, but in conversation, particularly in those who have ulceration of the larynx, fine particles are thrown out—so fine and light that they float and are disseminated with the movements of air, and may even pass to a distance of many feet before they settle. The more solid expectorations, thrown to carpets and surrounding structures, will dry, holding the bacilli, and in darkened places these bacilli may live even as long as ten months. In the meanwhile, if comminuted and thrown up with the dust, then inspired by the susceptible, disease will be produced. In homes, in public places, schools, cars, and even in streets, powdered expectorations of tubercular patients are disseminated with the dust, and possibilities of harm exist. Particularly is there danger in dwellings where the air is seldom changed, and where the rooms are always dark, either through the fault of construction or the desire of the good wife to keep the carpets from fading. Dust in the neighborhood of a consumptive's bed has been discovered virulent six weeks after the patient's death. The accumulation of dried sputum in a sick-room where frequent cleansing and the flooding of the room with sunlight have not been practiced, allows of a cumulative effect, rendering it not only noxious to the well, but re-infective to the sick.

Bacilli are further disseminated by the means of flies. This other little beast is a natural scavenger, feeds on excrements and sputum, and will carry from its feast dabs on all its feet, which, until the same dry,

* Read before the Hudson County Medical Society.

are capable of disseminating bacilli. That may be for more than a few hours. In its proboscis and intestinal tract, the bacilli will live and propagate, and from four to six days after its feast, the fly will defecate pathogenic germs. The excrement from a dozen flies have proven lethal to a guinea pig inoculated abdominally with the same.

Consumption is a disease of civilization. It is a home disease. It is always found in houses, never in tents or in the open. As society condenses, so does consumption increase. We find more cases in tenements than in private houses. It is a disease that loves the dark and the foul. It disappears with sunlight, pure air, and cleanly habits. Poverty, the alcoholic habit, poor home sanitation, breed weakly children. The rapid growth of tissue in childhood and the weakened resisting power of growing tissues increase the susceptibility of children to the tubercular germ. Statistics gathered in New York City show the prevalence of tuberculosis in tenement houses. In one block, containing a population of 3,688, there were 241 cases of tuberculosis.

Tuberculosis is contagious. It is propagated by a germ. The germ is found in expectorations. If all expectorations were caught and destroyed, consumption would cease. Want of care in spitting disseminates the disease. Darkness and impure air keep the germs alive, while sunlight, fresh air and cleanliness weaken the power of the germ. Terminal disinfection is illogical and a failure. Frequent cleansing of surroundings, good ventilation, and strong sunlight inhibit the disease.

IS THE STATE MEDICAL EXAMINING BOARD A SUCCESS?

By John R. Stevenson, M. D., Haddonfield.

California was the first state to establish, in 1876-8, a mixed board of medical examiners. This was a remarkable period. It marked the beginning of the second century of Republican government, and the commencement of the era of Trades Unions and Trusts displacing individual effort. The law was the starting of a movement from West to East, thus reversing the prior order of things. California had been rapidly settled by a mixed people from all parts of the globe, and being isolated from the central authority, needed, for a time, a strong and paternal government even if in-

compatible with the personal liberty upon which the United States Government is founded. It is universally agreed that the State has the power to license and regulate the practice of medicine and to prescribe the qualification for a doctor. For the latter, the first essential is a good moral character, another is a fair academic education, and most important, a good medical training. Quacks or irregular practitioners, wanting in all these requisites, have always been ready to take advantage of the innate weakness of human nature in sickness, to call in the aid of the mysterious and unknown in the healing art.

The great question comes up; Who is to decide the matter? Answers to this may be found in our own State history. When the two colonies of East and West Jersey were united into one (1702) the Royal Governor decided who should practice, and issued his license to doctors. As population increased, and after the organization of the State Medical Society (1765), the authority was handed to the Judges of the Court, who had candidates examined by members of this Society. This was done under a monarchical government and continued under the present republic until 1816, when the legislature transferred the whole power to the State Medical Society. During this time there had been only one healing code, the so-called Allopathy. Early in the last century there arose a new and definite plan of cure, Homeopathy, and subsequently another, Eclectics. During their persistent claims for legal recognition the laws against irregulars became so loose and inefficient that these gentry began to take courage, so that the learned and wise Dr. Stephen Wickes, Chairman of the Standing Committee of the New Jersey Medical Society, foreseeing the result, had it (1866) renounce all powers except the right to practice medicine and collect bills, stating that the old regular (Allopathic) school asked for no legislation, no other one could get any.

This left it still unsettled who should decide on the State requirements for the practice of medicine. In 1880, a law was passed compelling all practitioners to file in the County Clerk's office a diploma from some reputable college. Of course, as the constitution of the United States prohibits *ex post facto* law, New Jersey had to legalize all who, under its loose laws, had been allowed to prescribe for a specified number of years. This law being enforced, soon reduced the number of quacks, but did not raise the standard of education. The

creation of the State Medical Examining Board (1891) composed of adherents of the three schools of medicine, apparently for a time still farther reduced them by taking in and legalizing Homeopaths and eclectics, who had heretofore been deemed irregular, but in reality, the number of competing physicians for the business had not been diminished. Moreover, the regular profession placed itself before the public as either acknowledging its own practice to be doubtful and uncertain, or condoning and accepting the visionary laws of "*Similia similibus curantur*" and that vegetable remedies are alone fit to cure disease. This has greatly diminished the professional and social status of graduates of the regular school; at least this is so in the section which comes under the writer's observation, and has largely increased the pecuniary receipts of other practitioners.

The State Board of Medical Examiners had no sooner got into full control, than that *rara avis*, the bone doctor, yet remembered by the older physicians, and the still rarer *potw-wow* professor, took a new lease of life;—new names, and became transformed into to new cults, Osteopathy and Christian Science, which are growing like the gourd in the night, demanding legal recognition alongside the *sciences* of Homeopathy and Eclectics, without which they must sooner or later sink into oblivion. Shall the medical profession swallow these and farther liberalize its views of medical practice?

Experience tends to impress upon us the view that no board composed of doctors only, can prevent the people from looking on them with a suspicion of interestedness. Who shall decide? The State can declare how much knowledge, academical and medical, shall be legal qualifications; that diplomas from institutions that fulfill the standard shall alone be accepted for a license to practice medicine. Possibly, as it is proposed in New York, the Board of Health might be the referee. Fraudulent colleges and bogus diplomas, like financial institutions and their certificates, are subject to common law prosecution, as are also doctors, who although educated, choose to treat disease with "isms," whereby their patients are injured or killed. It is not the province of the regular profession to protect the community from quackery, or to say what kind of doctor may be, or when he shall be called by the individual. This is the duty of the government, which in the

past has always been ready to accept its advice.

Reports from County Societies.

ATLANTIC COUNTY.

W. F. Ridgeway, M. D., Secretary.

The annual meeting of the Atlantic County Medical Society was held at Hotel Windsor at 12 M. Jan. 11, 1907. In the absence of the President, Dr. E. C. Chew, the Vice-President, Dr. E. H. Harvey presided. It was the largest meeting of the Society ever held, over 40 of the 60 members being present. Various communications were read with regard to the visit of Dr. J. N. McCormack and on methods of legislation. The following resolutions from Dr. Darnell were presented, and upon motion of Dr. Senseman, were adopted.

Whereas: The newspaper columns of the lay press of Atlantic City frequently contain articles describing surgical operations with mention of the names of attending surgeons and their assistants; also news items giving details of the illness of citizens, in which mention is made of the attending physician as well as the names of the patients, and,

Whereas: The technical details accompanying these articles in the lay press frequently indicate that the information has been furnished by someone conversant with medicine, and in most instances the information is made public without the knowledge or consent of the patient, and,

Whereas: Such publications are contrary to the best interests of the public as well as the medical profession, and are contrary to the spirit of medical ethics, and,

Whereas: It is believed that the publication of the names of the physicians in connection with news items in the lay press concerning medical and surgical cases is not essential to the enlightenment of the public, therefore, be it

Resolved: That such publication be and is hereby condemned by the Atlantic County Medical Society, and be it further,

Resolved: That it shall be the duty of the Secretary of this Society to have placed in a scrap book, and read aloud to the Society at each regular meeting, all such articles as shall have appeared in the lay press since the last meeting, and that each member whose name appears therein shall be required to attach a written explanation thereto, and be it further

Resolved: That the members of this Society, in order to prevent such publications in the future, shall make such representations to the superintendent and other officers of the local hospital as will, as far as possible, prevent resident physicians, nurses, attendants and others from giving to the lay press such information as is referred to in the foregoing resolutions.

The annual election resulted in the choice of the following: President—Dr. E. C. Chew; Vice-President—Dr. C. M. Fish; Secretary and Treasurer—Dr. Wm. F. Ridgeway; Reporter—Dr. A. B. Shimer; Annual Delegates—Drs. Theodore Senseman and E. C. Sharpe; Member Board of Censors—Dr. E. A. Reiley.

ESSEX COUNTY.**Frank W. Pinneo, M. D., Reporter.**

The Essex County Medical Society held a special meeting Friday evening, February 1st, in the hall of the Public Library, Newark, to meet Dr. J. N. McCormack, representing the American Medical Association, who spoke on what a County Medical Society might be and do. He spoke at length and in detail on matters of organization, of education, of public policy, as one thoroughly in earnest in believing that the medical profession ought to be in the van of activities for its own progress and the public good. His address was interesting and well received. Members constituted his audience although the public also was (through them) invited. A committee was appointed (Drs. C. J. Kipp, W. J. Chandler and T. W. Harvey) to consider and report plans for acting on any suggestions the address contained.

The Society met again, Tuesday evening, February 19th, to hear Dr. J. H. Musser on "Diseases of the Pancreas." He considered Acute Hemorrhagic and Suppurative and Chronic Pancreatitis with the light that the latest cases shed on this interesting subject. He could not say that the laboratory had found a means of prompt and clear diagnosis, in spite of the work done on this line. We were glad to welcome Dr. Musser again and appreciated his exhaustive address.

The committee on Dr. McCormack's suggestions reported a plan for ten scientific meetings—monthly, except in July and August—with an address, or other similar attraction, and specified members to open discussion, not more than thirty minutes at such meetings being allowed for business. The report was referred to the standing committee on program and the committee on by-laws. The prospect is good for activity and progress.

The next meeting will be in March, when Dr. A. J. McCosh is expected to address us, and the annual meeting will be held in April.

GLOUCESTER COUNTY.**H. A. Wilson, M. D., Reporter.**

The annual meeting of the Gloucester County Medical Society was held on Jan. 17th.

The subject for the meeting, Pneumonia, was presented by Dr. H. B. Diverty and was followed by an able paper by Dr. Thomas G. Ashton, of Philadelphia, on "Some Points in Physical Diagnosis with Especial Reference to Croupous Pneumonia." After general discussion a copy of the paper was requested for publication in the Journal.*

Drs. M. J. Luffbary, Luther, M. Halsey, James Hunter, Jr., Geo. Evans Reading and H. A. Wilson were appointed a committee to arrange for the coming meeting to be addressed by Dr. McCormack.

The following officers were elected for the ensuing year: President—M. J. Luffbary, Glassboro; Vice-President—W. G. Simmons, Swedesboro; Secretary and Treasurer—Geo. Evans Reading, Woodbury; Reporter—H. A. Wilson, Woodbury; Censors—Harry A. Stout, Wenonah; L. M. Halsey, Williamstown; James Hunter, Jr., Westville.

*Dr. Ashton's paper will appear in the April issue of the Journal.

SUSSEX COUNTY.**Shepard Voorhees, M. D., Secretary.**

The Sussex County Medical Society was unfortunate in the day appointed to meet Dr. McCormack, Thursday, Feb. 5th, 1907. The severe wind and snow storm of the fourth and fifth brought nearly to a standstill all forms of transportation. No trains arrived in Newton, the place of meeting, until the afternoon of the latter date. The country roads were blocked with snow. Dr. M. B. Hughes, of Branchville, the President of the Society, was the only member present from out of town. The afternoon meeting of the society was abandoned.

Dr. J. N. McCormack, after an all day endeavor, arrived in Newton, from Belvidere, one hour before the time appointed for the evening meeting. About fifty representative citizens braved the storm and assembled in the court-house hall at the appointed hour. They were all well repaid for their exertions, and speak in high commendation of the doctor's address. There is universal regret that the night was so unfavorable, the occasion was deserving of a full house.

The local physicians were greatly disappointed because of the weather conditions, but they find satisfaction in the very favorable way the doctor's address was received and they were especially pleased with the conference held at the close of the public meeting.

In the future, when such interesting occasions are arranged for them, they hope a season of the year will be selected when climatic conditions in North Jersey are likely to be more propitious.

CONGRESS OF AMERICAN PHYSICIANS' AND SURGEONS.

The Preliminary Program of the seventh meeting of this Congress, to be held in Washington, D. C., May 7th, 8th and 9th, 1907, has been issued. The meetings will be held in the Convention Hall of the Arlington Hotel. Dr. Reginald H. Fitz, M. D. L.L. D., of Boston is the president, Dr. C. J. Kipp, of Newark, is one of the vice-presidents, ex officio—as president of the American Ophthalmological Society.

The subject to be considered May 7th is "The Historical Development and Relative Value of Laboratory and Clinical Methods in Diagnosis," the papers to be read being by Dr. William Osler, of Oxford, England, on "The Evolution of the Idea of Experiment in the Study of Medicine;" by Dr. L. F. Barker, of Baltimore, M. D., on "Neurological and Psychiatric Diagnosis;" by Dr. Alfred Stengel, of Philadelphia, Pa., on "Chemical and Biological Diagnosis;" by Dr. R. H. Cabot, of Boston, Mass., on "Physical Diagnosis." Discussion of these papers will be led by Prof. Fred'k Muller, of Munich and Dr. George Blumer, of New Haven, Conn.

On May 8th the subject will be "The Comparative Value of the Medical and Surgical Treatment of the Immediate and Remote Results of Ulcer of the Stomach." Papers will be read by Dr. John H. Musser, of Philadelphia, Pa., and Dr. C. G. Stockton, of Buffalo, N. Y. on "The Indications For, the Methods Of, and the Results to Be Expected in the Medicinal Treatment;" and by Dr. Wm. J. Mayo, of Rochester, Minn., on "Surgical Treatment of Acute Ulcers of the Stomach, Including Perforations and Hemorrhage;" and by Dr. John C. Munro, of Boston, Mass.; on "Chronic Ulcers and the Indica-

tions for Surgical Treatment. These papers will be discussed by Dr. B. G. A. Moynihan, of Leeds, England; Dr. A. Jacobi, of New York and others.

PROTECTING OUR MILK SUPPLY.

Two circulars have recently been issued by our State Board of Health, printed in large type on muslin to be posted in every Dairy in the State. We give below one of them in full and the headings of the other. EDITOR.

BOARD OF HEALTH OF THE STATE OF NEW JERSEY.

ADVICE TO DAIRY MEN CONCERNING THE PRODUCTION OF CLEAN MILK.

CARE OF THE COWS. The health of the cows should be carefully guarded, and they should be curried and brushed daily to prevent hair, dust and dried excreta from falling into the milk. The udders and teats should be made clean before milking.

COW STABLES. Cow stables should be well lighted and well ventilated. The ceilings and side walls should be smooth and dust-tight, and be free from ledges and projections upon which dust may lodge. The air space allowed for each animal should not be less than 500 cubic feet. The floor should be water-tight, and the floor of the stalls should be graded to permit fluids to flow away from the animals. Mudholes in the barnyard and pastures should be filled. Excreta should be removed from the stable building at least as often as once in each day, and it should not be deposited near the building nor in the enclosed yard in which the cows are allowed to take exercise, sun and air. The interior of the stable should be kept clean and free from all accumulations. Facilities should be provided to enable the milkers to wash their hands and put on clean outer garments.

THE WATER SUPPLY. The water supply for dairies should be pure, abundant and easily accessible. No water which is obtained from surface wells located in the immediate vicinity of dwellings, outbuildings, or other known sources of pollution, should be used on dairy premises, and every such well should be filled with clean earth and its use should be abandoned. No well which has become contaminated because of the pollution of the soil of the locality can be made safe by cleaning. A well once contaminated by receiving its supply of water through soil which has been defiled by a leaky drain, a cesspool or a privy vault, or by waste liquids cast upon the ground surface, cannot be made safe by any process of cleaning, and the use of water from such a well may at any time be followed by an outbreak of typhoid fever, diarrhoea, or one of the other water-borne diseases. If surface wells (those which are dug or driven) are used, they should be located at least three hundred feet from any known or apparent source of soil pollution, and if possible they should be located on elevated ground.

COOLING THE MILK. Immediately after the milk is drawn from the cow it should be transferred to the containers in which it is to be sent to market, and be cooled to 50 degrees F. or below. The cooling process should be conducted in a manner which will not expose the milk to con-

tamination. If the milk is cooled by passing it over pipes or surface containing ice-water, this operation should only be performed in a tightly closed apartment which is kept scrupulously clean and which is used for no other purpose. The floor of such rooms should be kept wet when the milk is being cooled, and no person except the necessary employees should be permitted to enter it.

PROTECTION OF MILK. The outer garments of the persons who do the milking should be clean, perfectly white; the milker's hands should be clean; the milk should be received in a clean pail through a cloth strainer, over a small opening in the cover of the pail; care should be taken to avoid stirring up of dust before milking; the containers into which the milk is placed for storage or transportation should be tightly covered to prevent the admission of dust; the pail strainers and all utensils and containers should be sterilized before use by being immersed in boiling water for at least thirty minutes or by exposure to a temperature of not less than 240 degrees F. for not less than thirty minutes in a suitable steam sterilizer; the milk should be transferred at once after milking to the bottles or cans in which it is to be sent to market, and the cooling process should be rapid.

INFECTIOUS DISEASES ON DAIRY PREMISES. The occurrence of a case of typhoid fever, scarlet fever or diphtheria on a dairy premises should be at once reported to the local health board, and the patient and all infected persons should be removed from any possible contact with the milk.

Circular 116, entitled "CLEAN MILK," will be sent to any address upon application to State Board of Health, Trenton.

The other circular printed in large type on cloth to be posted in each dairy of the State, contains: "ACT OF THE LEGISLATURE GOVERNING CREAMERIES" and "RULES AND REGULATIONS FOR THE MANAGEMENT OF CREAMERIES;" and at the bottom the words: "Penalty for Violation of the Law, Forfeiture of License and Fine of \$200.00."

BOARD OF HEALTH OF THE STATE OF NEW JERSEY.

Monthly Statement—January, 1907.

The number of deaths reported to the Bureau of Vital Statistics during the month of January, 1907 was 3,289, an increase of 1,019 over the number reported during the previous month. By ages, there were 486 deaths among infants under one year, 202 deaths of children over one year and under five years and 770 deaths of persons aged 60 years and over. Compared with the preceding month the reports show an increase of 59 deaths from pulmonary tuberculosis; pneumonia shows an increase of 105, and other diseases of the respiratory system show an increase of 64. These figures are not unusual for this period of the year, and indicate the unfavorable influence of certain seasonal conditions on the affections included in this group.

The number of deaths from typhoid fever (45) shows a slight diminution compared with the two previous months (December, 47 and November, 53); average (9.33) for the six preceding months.

Diphtheria caused 80 deaths, while the average for the previous six months was only 45.33. This increase is probably partly due to a somewhat wider prevalence of the infection which generally

occurs during the colder months, but failure to employ antitoxin early and in large doses in the case of every individual who is attacked by diphtheria is the most important factor in accounting for the increased fatality. Diseases of the nervous system caused 100 more deaths than during the month of December, and 88 more than the average for the six months from July to December, 1906. Bright's disease is charged with 200 deaths, which is 41 more than the number for December.

The following shows the number of certificates of death received in the State Bureau of Vital Statistics during the month of January, 1907, and also the number of deaths from certain selected causes. Causes of Deaths and number of certificates received:

Typhoid fever, 45; Measles, 4; Scarlet fever, 11; Whooping cough, 46; Diphtheria and croup, 80; Malarial fever, 3; Tuberculosis of lungs, 307; Tuberculosis of other organs, 53; Cancer, 127; Cerebro Spinal meningitis, 23; Dis. of nervous system, 417; Dis. of circulatory system, 343; Dis. of respiratory system (Pneumonia excepted), 215; Pneumonia, 332; Infantile diarrhoea, 171; Dis. of digestive system (Infantile diarrhoea excepted), 203; Bright's disease, 200; Suicide, 22; All other causes, 687; Total, 3,289.

STATE TUBERCULOSIS SANATORIUM.

The following amendment to the Act Establishing the State Sanatorium has been introduced into the Legislature:

AN ACT TO AMEND AN ACT ENTITLED "AN ACT TO ESTABLISH A SANATORIUM FOR PERSONS AFFLICTED WITH TUBERCULOUS DISEASE AND TO PROVIDE FOR THE SELECTION OF A SITE AND THE ERECTION OF BUILDINGS THEREFOR AND THE GOVERNMENT THEREOF" approved April third, one thousand nine hundred and two.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. Section nine of the Act to which this is an amendment, be, and the same is, hereby amended to read as follows:

9. Any person who has been a resident of this State for at least one year continuously next preceding the application for his or her admission to said sanatorium, and who is afflicted with tuberculous disease of the respiratory organs of a curable nature may be admitted into said sanatorium, and treated therein, subject to such rules and regulations as the Board of Managers may from time to time prescribe, and at a cost to be determined in the following manner:

a. Persons of sufficient ability to pay for the same or who have persons or kindred bound by law to maintain them, shall pay for their care and treatment at a rate to be determined by the Board of Managers.

b. The charges for the care and treatment of such persons who have a legal settlement in some city, borough, town or township or other municipality of this state, and who are received at said sanatorium on the request of the overseer of the poor of said city, town or township, or other municipality shall be paid by such city, borough, town or township, or other municipality.

c. Persons of indigent circumstances, and who do not come within the foregoing two classes, may be treated therein without cost, provided, however, that before any person shall be admitted as an indigent patient a written application to the Board of Managers for such admission shall be signed by him or her, or by some relative or friend of such indigent person, which application shall be presented to the judge of the Court of Common Pleas of the county within which such indigent person resides; and such judge, upon such application, shall, upon being satisfied that such person has been a resident of this state for at least one year continuously next preceding such application, and is in indigent circumstances, approve of such application in writing.

2. No person shall be received into the sanatorium who has not a certificate signed by some physician or physicians to be selected by the Board of Managers, certifying that such person is afflicted with tuberculous disease of the respiratory organs of a curable nature.

3. All acts and parts of acts inconsistent with the provisions of this act are hereby repealed, and this act shall take effect immediately.

OSTEOPATHY AND REGULAR MEDICINE.

Under this caption the Editor of *Critic and Guide*, in its December issue, gives the following "Comments" on a communication received, signed Asa Willard, Osteopathic Physician, Missoula, Mont. The osteopath criticises an editorial in the *Critic and Guide* headed "Osteopathy and Smallpox" "which appeared in our December Journal), and cites two instances of mistake in diagnosis made by regular medical practitioners.—Editor.

Dr. Willard gives two examples of mistakes in diagnosis by regular physicians. He could have saved himself the trouble, as I myself could cite dozens of cases in which my professional brethren, regulars, have exhibited a most deplorable and absolutely inexcusable degree of ignorance. Nobody asserts that regular medicine is perfect, or that there are no ignoramuses in the regular medical profession. I condemned osteopathy not on account of the mistake of the two osteopathic doctors; that was given merely as an interesting incident. I condemned and condemn osteopathy as an exclusive system. I condemn just as emphatically the physician who limits himself in the treat-

ment of his patient to drugs and drugs only, or to hydrotherapy, or electricity, etc. The human organism is a wonderful and exceedingly complicated piece of mechanism, the causes which may get it out of order are exceedingly numerous, and, therefore, when it does get out of order we are obliged to use every possible available agency if we expect to put it back in order again. The physician who treats all diseases by one exclusive system is either an ignoramus or a charlatan, though he may not be conscious of either, and may be sincere.

Let me take a little example, which will illustrate the matter and will perhaps convince Dr. Willard that I am not so immature in condemning osteopathy and other exclusive or sectarian systems.

We will take Functional Sexual Impotence or Spermatorrhea. Pathologically these are trifling affections. Anatomically there are practically no lesions. And still I find that in treating patients afflicted with those diseases I can obtain but slight results if I limit myself to one kind of treatment. I find that in order to bring my patients to a speedy cure I must make use of (1) drugs, both locally and internally, (2) cold water applications—hydrotherapy, (3) electricity in its various forms, (4) vibratory massage, (5) instrumentation, sounds, dilators, rectal tubes, etc., and last, but not least, (6) moral suasion—psychotherapy. Not counting instructions as to diet, sleeping, etc. Here in an apparently trifling affection I find myself obliged, in the interests of my patients, to make use of six or seven different agencies. And Dr. Willard dares to imply that all diseases can be treated osteopathically, by massage?

But this is not the only point. I condemn osteopaths not only because they treat diseases improperly, but because they are not competent to treat diseases at all. And they are not competent because they are not diagnosticians. They don't study enough. Their course is too brief and too trivial. They have no laboratories and no hospitals to speak of. They accept as students the very lowest kind of ignoramuses. I know personally of several people, quite ignorant, who studied osteopathy "by correspondence." They received their "diplomas" after a few months' study and are now styling themselves "osteopaths" or osteopathic physicians. In one case the man was so ignorant that a woman friend answered the questions for him, but he got his diploma and is now a "physician" (save the mark!). Just think of learning to treat the human body by correspondence!

We, regulars, are constantly increasing our curricula and lengthening our courses, because we recognize that medicine is one of the most difficult studies in the world—and the sectarians and quacks come around and want us to believe that they are competent to treat the complex human organism after one or two courses of five to six months each, or even after a correspondence course! No, we are not quite so gullible.

I am not a blind eulogist of everything in "regular" medicine. I know its failures and shortcomings better perhaps even than the hostile sectarian, for I gave the subject an unbiased historical study. I will even admit, if it pleases Dr. Willard, that there are regular practising physicians who are much better fitted for the job, say of tending bar. But, and here is the point, the proportion of dangerous ignoramuses is after all *much smaller* in the regular profession than

it is among the irregular quacks. And, as I said many times before, the future is entirely in the hands of regular, scientific medicine. And there is no excuse for any sects *now*. There can be no difference in the study of anatomy, surgery, chemistry, etc. People may differ only in their treatment. And we now permit everybody to treat his patients according to his ideas. We have freed ourselves from the thralldom of authority in this respect. But we have a right to demand that before a man engages in the serious occupation of treating human diseases, he give proof of his competence to diagnose a disease, to differentiate between one disease and another.

In conclusion, I would ask some prominent osteopath or physio-medic to outline for me briefly his treatment for, say: malaria, scabies, lues, specific (gonorrheal), ophthalmia, specific urethritis, purulent cystitis, pyelitis, and pardon the finale, pediculosis pubis. I am very curious to know. I am always anxious to learn, and it is never too late to do so.

Correspondence.

"Mr. Editor, Trenton, N. J., Feb. 22, 1907.

Dear Sir: I notice the following in the Trenton Times: "Senator Ackerman, of Union County, introduced this week in the Senate a bill for the incorporation of pathological and anatomical associations for the advancement of medical and surgical science. The bill gives any three or more physicians authority to form such organizations; authorizes officials of public institutions to deliver to such organizations dead bodies in their possession not claimed by relatives; provides a penalty for traffic in dead bodies." Why do the physicians of Union County want a special law for themselves? In 1895 there was a very comprehensive law passed, entitled "An Act to Provide for the Incorporation of Pathological and Anatomical Associations for the Advancement of the Medical and Surgical Sciences," giving said associations the right to all unclaimed bodies dying in prisons, jails and asylums.

Four physicians had been working together along the lines now proposed by the A. M. A., meeting weekly, and they finally came to the place where they felt the need of dissecting for anatomical and surgical work.

We found there was no law in our state making the procurement of dead bodies legal. Dr. W. L. Wilbur, from Mercer County was then in the Assembly—we had a bill drafted, using that of Pennsylvania for a basis, and it went through the Assembly without opposition. In the Senate it was opposed by Senator Voorhees, who quoted, "Rattle his bones over the stones" etc., to some effect. Dr. Perry Watson came down and assisted us in enlightening the senators. Senator Wm. Brady acted as our champion, and with the able assistance of Dr. Parry, senator from Burlington, we got the bill through and it was signed by the Governor, March 21, 1895.

We immediately organized the Trenton Pathological Association with the following officers: President, C. F. Adams; Vice-President, H. B. Costil; Secretary, B. W. McGallian; Treasurer, H. B. Struble.

We had no difficulty in getting material, and did a lot of work for several years.

Very truly

C. F. ADAMS.

THE JOURNAL

OF THE

Medical Society of New Jersey.

MARCH, 1907.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any one failing to get the paper promptly will confer a favor upon the Publication Committee by notifying them of the fact.

All communications relating to the JOURNAL should be addressed to the Committee on Publication, 95 Essex Avenue, Orange, N. J.

In the article on Retrospection in the January issue of the Journal there were two or three mistakes that seemed rather comical and were due to the hasty adding of the last paragraph just as the Journal was ready for the press. The word "blackmail" was used instead of boycotting and the word "preparations" was omitted (in copying Mss) after the word "such" in the fourth line from the end. It is hardly necessary to state that the first mistake was not due to ignorance as to the meaning of the two words, and in the other mistake we could not intentionally have spoken of commending nostrums as ethical. We have no regret to express for having added that paragraph, but only for the haste that occasioned the errors. The confusion in the printing office resulting from the strike of employees caused this item of corrections to be mislaid and overlooked so that it failed to appear in the February JOURNAL.

The delay in issuing the Journal this month, which we exceedingly regret, has been unavoidable, being due to the strike in the printing office referred to above.

Just as the Journal goes to press we learn that the Osteopathic bill, No. 146, has been introduced into the Senate, which is more vicious than the bill of last year and there is a disposition to rush it through without time for proper consideration. The profession has a right to be heard on this important

matter which so vitally effects the health and lives of our citizens. We call upon our members to call the attention of the Senator and Assemblymen of their respective counties to the true meaning and the effects of this bill.

HENRY WHITELEY ELMER, M. D.

It is with profound sadness we announce the death of Dr. Henry W. Elmer, ex-President of the Medical Society of New Jersey—our highly esteemed and much beloved friend, and yet we find much to assuage our sorrow and produce full submission to the Divine will when we think of his long illness, during the latter part of which he was not able to see his friends, or even recognize the loved ones who so tenderly and faithfully watched beside him, ministered to his necessities and patiently waited for the summons that brought to him blessed release and the rewards that awaited so true and faithful a servant of God and of suffering humanity. No name in the long history of our Society is more honored than that of Elmer,—great grandfather (a distinguished statesman as well as physician) grandfather, father and brother of the deceased rendered most valuable service to our State Society in various positions that required professional ability, good judgment and fidelity, and which was recognized by their election to the highest office within the power of the Society to bestow—the presidency of the Medical Society of New Jersey, and in each case an honor that came unsought. Henry W. Elmer was no exception, ever ready to obey the Society's call to service, his discharge of duty was to the satisfaction of its members, and especially in the important position as Chairman of the Standing Committee for several years—a position which required much thought, good judgment and considerable time. One of his marked characteristics was his modesty. The writer, with several others, urged him at three annual meetings to allow his name to be presented for the third vice-presidency, which, according to custom, led to the presidency. Each time he positively declined

on the ground of unworthiness and that there were others more worthy of the honor. In 1902, he was nominated and elected to that office against his wishes, and, in regular course, in 1905 he was elected President of the Society.

Dr. T. J. Smith, a Fellow of our Society, and a near neighbor and close personal friend of Dr. Elmer, pays a fitting tribute to his memory which will be found in another column. We believe he voices the sentiments of all who knew and loved Dr. Elmer. Able, faithful and beloved physician; devoted, valued and honored member of the Medical Society of New Jersey; greatly esteemed, trusted and philanthropic citizen; true, genial and loved companion and friend, "Well done," we say, "worthy son of noble sires." But infinitely more blessed and satisfactory to him is the "Well done" that this worthy disciple of the Good Physician has received as he entered upon the rewards of faithful service and the loftier activities of the endless life.

D. C. E.

TYPHOID FEVER EPIDEMICS.

Up to February 1, 1907 eleven hundred and twenty-five cases of typhoid fever with 104 deaths! Such is the record of the fearful epidemic in Scranton, Pa. This enormous number of cases unmistakably pointed to the water supply as the source of the epidemic. Shall the warning that comes to us with such emphasis be heeded by the municipal and health authorities of our towns and cities, or will they treat the Scranton scourge as an act of providence and, lying down in a sense of security, thank God, that their localities have not been visited. It has been thoroughly demonstrated that *Typhoid Fever is a preventable disease*. Shall we ask—Is it then excusable for our authorities to fail to take every precautionary measure known to sanitary science to prevent this and all other preventable diseases? Nay, we will affirm that it is criminal, in the light of present knowledge, to fail to do so. The water supply is the most frequent and powerful agency in the spread of this disease when it is polluted, and the

utmost care should be exercised in selecting and subsequently guarding that supply. In the selection the "penny wise and pound foolish" policy always proves the most expensive in dollars and cents and in addition is most costly in its damage to health and destruction of life and the consequent accountability of those who adopt it. We should as physicians, each in his community, impress upon the citizens that the most essential thing and that of vast importance, is the best supply obtainable—that freest from present and possible pollution, and that *security* is of much more importance than cost. The physician's plea, backed by the prominent citizens and the health authorities should be emphatically brought to bear upon the municipal body voting the money, special emphasis being laid on the fact that cutting down the death rate and preventing disease will annually save the community vastly more than the few thousands in our smaller towns, or hundreds of thousands in our large cities than a first-class supply costs above that of the inferior system.

After the introduction of the best supply obtainable, the fact which the Scranton epidemic emphasises, should always be born in mind, that it should be properly operated and its purity zealously guarded. "Eternal vigilance is the price of liberty" and eternal vigilance is the price of freedom from the pollution of a water-supply that has been comparatively pure. It is generally conceded that no method of protection will render a water derived from a surface-gathering ground as pure as that which comes from deep mountain springs. Where the public supply comes from rivers, ponds or lakes, that are liable to contamination we believe the only safe course is the introduction of a proper filtration plant. Here again let us insist that the question of cost (proper cost, that which is free from all graft) should not be considered where the saving of human life and the prevention of disease are involved. The discharge of sewage which contains the typhoid bacilli, or of other pollution which seriously affects the citizens'

health, into the waters whence the supply comes requires this safeguarding. Several years ago it was noted in several of our large cities throughout the country that when the annual rainfall increased, the prevalence and death rate of typhoid fever also increased.

We cannot at this time elaborate another important point in reference to the introduction of water-supplies or purification plants which does relate to cost and should be considered—the cost of maintenance, which should be kept down to the minimum point consistent with careful management by able business and professional men and competent employees, free from graft and political party control.

It is not our purpose at this time to dwell upon the other sources of infection of typhoid fever as polluted wells, contaminated milk supplies, oysters fattened and “freshened” in polluted water, contact of hands with infected articles, flies, infected dust, etc.

New Jersey compares very favorably with other States in the low death rate from typhoid fever. The following figures show decided and steady progress made in the last five periods of five years each:

	Total Deaths, 10,000 popl'n.	Deaths per 10,000 popl'n.
1881 to 1885.....	3304	5.42
1886 to 1890.....	3193	4.61
1891 to 1895.....	2882	3.52
1896 to 1900.....	2347	2.61
1901 to 1905.....	1926	1.92

This progress has been due very largely to the introduction of public water supplies in our cities, and in some cases to the change in the source of supply—from an inferior to a better, as in Newark and Jersey City, both of which got their water supply formerly from Passaic river and had high death rates—in 1890 Newark had 194 deaths from typhoid fever and Jersey City had 159. When Newark received its water supply in 1892 from the Pequannock river its death rate was reduced nearly 70 per cent. Jersey City continued using the Passaic water and its high death rate continued until its source of

supply was changed, with the same result as in Newark.

Much credit is due to our State Board of Health for its efficient work in the inspection of streams and efforts for the removal of sources of direct contamination of them, as in the case of the water-shed of the Hackensack river where considerably more than 250 pollutions were located and have been corrected during the past five years. Its persistent work also for securing a clean, pure milk supply is worthy of special commendation, for to that work we owe the stamping out, and in some cases the prevention of serious epidemics of typhoid fever.

We have considered in the above editorial the water supply of our cities mainly, and incidentally the milk supply as the chief sources of typhoid fever epidemics, and the importance of remedial and preventive measures by the governing bodies and health authorities. But after all we must go to the fountain head and prevent the beginnings of the streams of infection. The individual physician dealing with the individual case. He has it largely in his power to prevent that case from becoming a source of infection to others, and he is not free from responsibility for such results if he has failed to use the approved precautionary measures to prevent the spread of the disease. We believe the essential requirements are:

1. Early diagnosis of the disease. It is very important, if typhoid fever is suspected, to put the precautionary measures in operation and forward a specimen of the patient's blood to the State Laboratory of Hygiene for examination; if reported as giving a negative result do not rest on that as the Widal test sometimes fails in the very early stage of the disease; send another specimen in a few days which will probably confirm the diagnosis. (2.) Ascertain if possible, the source of the infection. If a polluted well report it and have the well closed, as the water of a well so polluted is not thereafter fit for use. If the milk is suspected, enquire if others using it are affected; if there is a case of the disease in the dairyman's family, or among his employees, report at once to the health board. (3.) The safe disposal of the excreta, the typhoid bacilli are eliminated in the urine and feces; they should not be allowed to get into the wells or streams; thoroughly disinfect the excreta and prevent them from becoming, what they

would otherwise be, the most effective spreaders of the disease. (4.) Fully instruct the attendants concerning the handling and disposal of the food as well as the excreta and the importance of preventing, as far as possible, flies from coming in contact with either.

The typhoid organism persists for an indefinite time, often for many months, in the urine of persons who have been affected with the disease. If the attending physicians would notify every convalescent from typhoid fever that he is likely to distribute the infection for a long period, and that the urine should therefore be faithfully disinfected *until* repeated examinations have shown that it no longer contains the typhoid bacillus, the spread of this disease would be still further restricted. It should also be remembered that infection of the hands of persons who are carrying the typhoid bacteria in their bladders is liable to occur, and such individuals should not be employed in the salesrooms of bakeries, confectionary establishments, nor on any dairy premises, nor in connection with the distribution and sale of milk. Samples of urine should be sent to the State Laboratory of Hygiene from time to time, and the examination report will show when the urine of the individual has been freed from the typhoid infection.

LIFE INSURANCE COMPANIES THAT ARE NOT SEEKING CHEAP MEDICAL EXAMINERS.

We herewith publish a list of the life insurance companies paying a \$5 flat fee, as far as known to us. If our readers know of others they will please inform us:

Aetna Life, Hartford, Conn.
American National Insurance Co., Galveston, Texas.
Citizens Life, Louisville, Ky.
Capital Life, Denver, Col.
Fort Worth Life, Fort Worth, Texas.
Manhattan Life, New York City.
Massachusetts Mutual Life, Springfield, Mass.
Mutual Benefit Life, Newark, N. J.
National Life, Montpelier, Vt.
Northwestern Mutual, Milwaukee, Wis.
Pacific Mutual Life, San Francisco, Cal.
Provident Life and Trust, Philadelphia.
Reliance Life, Pittsburg, Pa.

We believe that these companies are thoroughly reliable, that they do not pay their officers excessive salaries, and are not mixed

up with trusts and political parties. They should be favored in every way possible by members of the medical profession.

Dr. Randall, Medical Director of the American National, in a letter stating that the company has adopted the \$5 fee, says: "*It is the desire of this company to employ only the best examiners, and they realize they can only get good men by paying a reasonable fee.*"

That is good common sense and shows that this company is run on sound business principles.

One of the most praiseworthy acts of Governor Hughes, of New York, was his re-appointment of Dr. Alvah H. Doty as Health Officer of the Port of New York. From our knowledge of the man, his scientific methods and eminently practical work, we venture the assertion that no better appointment could have been made. The citizens of New Jersey as well as New York are to be congratulated on having so able and efficient a guardian of their lives and health against the incoming of serious epidemics from infected ports.

The visits of Dr. J. N. McCormack, of Kentucky (representing the American Medical Association), to our County Medical Societies were greatly appreciated, his addresses were intensely practical and helpful. The reports from some of the County Societies refer to his visits and we shall make further reference to his good service, in the April JOURNAL.

MISCELLANEOUS ITEMS.

The Influence of Early Feeding in the Treatment of Typhoid.—F. J. Smith would avoid hard, indigestible, and sharp-edged seeds of such fruits as nuts, grapes, oranges, strawberries, figs, etc., but does not object to giving the strained juice of such fruits as are juicy enough for the purpose. Moreover, he would avoid giving any food too freely or injudiciously, but he does not interdict a bit of bread and butter or an egg simply because a patient's temperature is not absolutely normal. He has on record a series of 113 cases with twenty-four deaths occurring in hospital practice, but of the deaths but four took place after solid food had been given. The remaining twenty had received no solid food. He

compares his own cases with those of the other physicians in the same hospital. His own patients were placed on food (bread and butter or rusks, fish, and meat) and were fed about two weeks earlier on the average than the cases of his colleagues. His own cases had 2 per cent. of complications (venous thrombosis, peritonitis, and abscess formation), while the collective cases (1,429) of his colleagues showed 10 per cent. of complications. This remarkable immunity of the "early-fed" cases can only be explained by the better resisting power of the patients. The less frequent occurrence of thrombosis (Smith 1 in 113, colleagues 59 in 1,429) may be accounted for by the fact that the author's cases had a diet containing less calcium than the patients obtained on the ordinary milk diet. Early feeding seems to have but little effect on the occurrence of relapses. Other interesting points of comparison are given.

The Treatment of Typhoid Fever.—The paper by W. B. Thistle is an inquiry regarding the effect of purgatives on the intestinal lesions of typhoid. He believes that the battle is mostly won or lost in the first week of the disease. If nothing is done to limit the infection of the glands or of the body, the result is a matter of chance. He believes that the judicious use of purgatives greatly limits the number of bacilli gaining access to the intestinal glands, and thus limits the destructive process in them. He has never encountered during the period in which he has relied on purgation a fatal perforation or hemorrhage. As soon as a case comes under his care he sweeps the intestines clear as quickly as possible with purgatives, giving usually a few grains of calomel followed by half an ounce of some saline. He repeats this process day after day, the object being twofold. First, to prevent additional infection of the intestinal glands, and, second, to abstract toxins from the body by way of the bile stream and the intestinal secretions. The time to cut off or attack the bacilli is, of course, before they are carried to the glands; while they are in the drainage area, which in the case of the intestinal glands is the intestinal mucosa and the intestinal contents. If purgatives are freely and frequently used, and are efficient in the early period of typhoid infection, it must be that many bacilli are removed from the drainage area that would otherwise go to increase the number already in the glands. If the purgative is repeated day after day and at the same time an antiseptic is given, the effect, in so far as the drainage area of these glands is concerned, is identical with the surgical procedure of bathing an infected surface with an antiseptic lotion. The good effect upon the glands is due in both cases to the removal of bacilli from the drainage area, and the consequent curtailment of bacterial infection in the glands.—*British Medical Journal*.

Prognosis in Typhoid Fever.—L. Carl (*British Medical Journal*, February 4, 1906), discusses the prognosis of typhoid in relation to certain special factors, namely, the rate of the pulse, the agglutinative power of the serum, and the blood pressure. He finds that a slow pulse and a high agglutinative power existing contemporaneously are of favorable import, whilst the reverse of this (a quick pulse and low agglutinative power)

is serious. The two factors, to have any significance, must exist together. A quick pulse with high agglutinative power may coincide with or indicate a bad attack. The two factors are independent. The blood pressure is as a rule only slightly elevated. In man it seems probable that the cardiac inhibitory centers are specially sensitive to the typhoid toxins, hence the slow pulse and the occasional presence of bradycardia in favorable cases of typhoid. In severe cases the normal sensitiveness of the vagus is more or less lost; hence the quickened pulse, cardiac failure and lower blood pressure.—*Med. Age*.

Typhoid Nodular Colitis.—Whipple (*Johns Hopkins Hospital Bulletin*, August, 1906).—Whipple reports a very interesting case which was characterized (1) by the absence of typical clinical findings of typhoid, the symptoms of which were overshadowed by those arising from the heart valves. (2) The intestinal lesions were confined to the colon (post-mortem). (3) These lesions correspond closely to the description given by Orth and others of the so-called nodular colitis. He could find only two other cases with satisfactory reports, corresponding to this condition, in the literature. His summary in this article is as follows: (1) Typhoid intestinal lesions limited to the colon are very rare; (2) the term "nodular colitis" should be restricted to such cases as show a marked infiltration of the submucosa with wandering cells, giving rise to prominent isolated nodules having no relation to the solitary follicles which are comparatively unaffected. These cases are of rare occurrence. (3) The term lymphatic-hyperplasia may be used to describe the cases having a simple hyperplasia of the solitary follicles of the intestines and a relatively normal submucosa. These cases are commonly found at autopsy.—*Interstate Med. Journal*.

Early Bacteriologic Diagnosis of Typhoid.—H. Conrade (Bakt. Fruhdg. des Typh.) announces that an early diagnosis of typhoid fever can be made from the smallest amount of blood available for the agglutination test. The serum can be utilized for the agglutination test. It will be found sterile as the typhoid bacilli present are caught in the fibrin in the rest of the blood. Experiments with blood from 60 typhoid patients showed the presence of the bacilli in the coagulum from amounts of blood ranging between 0.05 and 0.2 cc. The little thread of coagulum is extracted from the capillary tube with forceps and transferred to a test tube containing 5 cc. of beef bile, with 10 per cent. peptone and 10 per cent. glycerin. The tube is then kept at a temperature of 37 C. for from 12 to 16 hours. It is then well shaken, and 0.1 and 1 cc. of the contents are spread on with a glass spatula on dried plates of litmus-milk sugar agar. In 24 of the 60 cases typhoid cultures developed on the plates, that is, in 40 per cent. Restricting the figures to the patients in the first or second week of the disease, the proportion was 50 per cent. By this simple means it proved possible to make a positive diagnosis even with the minimum amount of blood sent in for the agglutination test. He adds that the "bile cultures" offer a prospect of being able to detect typhoid fever in its earliest stage.

Obituary.

Henry W. Elmer, M. D.

By Dr. T. J. Smith, Bridgeton.

Another has fallen. This time it is our beloved friend, Dr. Henry W. Elmer.

In the death of Dr. Elmer, Cumberland County has lost an able physician, a skilful practitioner and a very worthy citizen; the medical fraternity a member whose achievements were to his honor and to whom his tragic and untimely death, on Feb. 13, 1907, is an irreparable misfortune.

Dr. Elmer was a man of fine physique and distinguished presence, which, with his natural nobility of character, made him an open-hearted, whole-souled and generous man and a strong friend. In everything he did, he was wonderfully full of life and vigor and possessed a large capacity for, and love of work.

His final and prolonged sickness cast a sadness over the entire community. He was known and greatly respected by all classes of society. His life had been so upright and generous, and his public and professional activities so varied and fruitful, always determined, as they were, by a broad-mindedness and an altruistic sense that few possess; it might be truly said that all felt they had a share in the heartfelt sorrow engendered by the illness of a friend continued through over two long years.

We occasionally find a community whose medical history is largely influenced by one family. The record of Dr. Elmer's family shows a direct descent through four generations of medical men, and each of them prominent during his time in the community and in the profession. In the record of public affairs, their names are found connected with every movement that worked for the public good, with the advancement of educational and charitable institutions, with the promotion of business enterprises and with advancing the interests of the medical profession through the varied activities of the local, state and national medical societies.

Dr. Elmer was born at the family residence on West Commerce Street, Bridgeton, April 26, 1847.

He fitted for college at the West Jersey Academy and graduated in the Arts at Princeton College in 1866. He then entered the medical department of the University of Pennsylvania and took his medical degree therefrom in 1866. After serving a year as house physician in Blockley Hospital, Philadelphia, he entered upon general practice with his father in Bridgeton in 1870. Here his scientific attainments and love for his profession soon secured him a large practice which continued to increase until it became imperative for him, through ill health, to retire from its exacting duties.

His pleasing personality endeared him to a host of friends, while his best skill was always held available for the suffering and the sorrowing, whenever and wherever it was sought. He was a conservative practitioner and a close student. He kept himself in familiar touch with the progress in the science and art of his profession. A high sense of honor and of the dignity of the profession controlled his intercourse with his professional brethren, toward whom he was always considerate and obliging.

Dr. Elmer was one of the most loyal members of the Cumberland County Medical Society. He was re-elected annually its recording secretary

from 1871 to 1895, and afterward its president. He was also an active member of the Medical Society of New Jersey; was chairman of its standing committee for six years previous to 1902, when he was honored by election as third vice-president of the Society, promoted to second vice-president in 1903 and first vice-president in 1904. In June, 1905, he was elected president of the Society and afterward became a fellow and trustee.

In May, 1901, Governor Griggs appointed him a member of the State Board of Health, whereupon he did efficient service in all the efforts of that board for the public welfare. Upon the establishment of the Bridgeton General Hospital and the organization of its Staff of Physicians and Surgeons, he was elected President of the Staff. The successful advancement if its work was largely stimulated by his thoughtful oversight.

Dr. Elmer was a clear and vigorous writer, and during his medical life, read a number of valuable contributions before his medical confreres. He was strongly interested in all educational movements, holding, as he did, the position of Vice-President of the West Jersey Academy, a preparatory school in Bridgeton, and had also assisted actively and financially in developing the Bridgeton Public Library and especially that part of its work of building and furnishing a reading and entertainment department for young boys.

Public and business affairs claimed a share of the doctor's attention. He was a director of the Cumberland National Bank, a director of the Bridgeton Gas Light Company and a member and trustee of the West Presbyterian Church.

It will be seen that Dr. Elmer followed an active and laborious life. The various organizations with which he was connected as well as his patients, were served with fidelity and ability. The varied demands upon his time and strength were always promptly and conscientiously met. In every position he held he purposed to do his whole duty.

The funeral services were held at the family residence and were largely attended. It was an intensely impressive service. The local physicians with representatives from the State Society attended in a body.

We have laid our brother away to rest. He was a noble man and a good physician. We cannot say a better thing of him.

PHARMACEUTICAL AND CHEMICAL PREPARATIONS APPROVED BY A. M. A. COUNCIL OF PHARMACY AND CHEMISTRY.

The following articles have been tentatively approved by the Council of Pharmacy and Chemistry of the American Medical Association. The list will be revised by adding other articles accepted and by omitting any which on further investigation may be found to conflict with the rules of the Council.

Following the name of each article is the name of the manufacturer, or, in case of foreign products, of the American agent; where no name is given the article is believed to be protected by neither patent nor trademark. The date following the article refers to the preliminary publication in *The Journal A. M. A.* When no date is given the description has not yet been published:

Acetone (P. D. & Co.), Sept. 15, 1906. Acetone Inhalant (P. D. & Co.), Sept. 15, 1906. Acet-theocinsodium (Cont. Color and Chemical Co.), Sept. 15, 1906. Adnephryn Emollient (Stearns &

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Co.). Vinum Extracti Morrhuae, Stearns (Stearns & Co.). Vioform (Bischoff & Co.). Vioform Gauze (Bischoff & Co.).

Xeroform (Heyden Chem. Works), Sept. 29, 1906, Oct. 13, 1906.

REPORT OF THE COUNCIL ON PHARMACY AND CHEMISTRY.

We reprint herewith from *The Journal* of the American Medical Association, for September 15, the first installment of the report of the Council on Pharmacy and Chemistry. Additional installments will appear from time to time. The importance of these reports is too evident to need comment. For the first time in the history of the organized profession, a scientific commission, whose ability and probity is above suspicion, has reported on preparations regarding which heretofore we have had only the report of those interested, financially and otherwise, in their exploitation.

ACETOZONE.

A mixture of equal parts of benzoylacetetyl peroxide and an inert absorbent powder.

Actions and Uses.—Benzoylacetetyl peroxide belongs to a class of compounds known as the organic peroxides in which an excess of oxygen has been combined in such a way that it is somewhat slowly given off in a nascent condition. On contact with water it hydrolyzes, forming benzo-peracid and aceto-peracid which exert marked oxidizing and germicidal action. In consequence of this change, these compounds are thought to be particularly adapted for internal administration. The germicidal and antiseptic properties of this substance have been attested by the experimental results of several observers. It has been used in ophthalmic, aural and nasal practice with asserted good effects as an antiseptic. It has also been applied internally, especially in typhoid fever, with a view to the disinfection of the intestinal canal, and appears to be an intestinal antiseptic. Dosage—Acetozone is generally employed in aqueous solution prepared as follows: Add acetozone to warm water in the proportion of 1 Gm. to 1000 Cc. (15 grains to the quart), shake vigorously for five minutes and allow to stand for about two hours. Decant the liquor as required. This solution may be drunk *ad libitum*, two quarts or more being taken by an adult in twenty-four hours. Acetozone is also used in oily solution as an inhalant. Manufactured by Parke, Davis & Co., Detroit, Mich.

ACETOZONE INHALANT.

A solution of benzoylacetetyl peroxide in liquid petrolatum. Formula: One hundred grammes contain: Benzoylacetetyl peroxide, 1.0 Gm.; chlorotone (chlorbutanol), 0.5 Gm.; Refined liquid petrolatum, 98.5 Gm.

Dosage.—It is to be inhaled in the form of a very fine spray, or nebula, best produced by an atomizer especially designed for oily liquids. Prepared by Parke, Davis & Co., Detroit, Mich.

ACET-THEOCINSODIUM.

Acet-theocinsodium, $C_7H_7N_3O_2Na + CH_3COONa$, a double salt of sodium acetate and 1,3 dimethylxanthine-sodium (theophyllinsodium).

Actions and Uses.—It has the diuretic properties of theocin, reinforced by the diuretic action of sodium acetate, and, being more soluble, it has been claimed to be more readily absorbed and better tolerated than theophylline. It is recom-

mended in cardiac affections, nephritis, dropsy, etc. Dosage—0.2 to 0.35 Gm. (3 to 5 grains), best given after meals. Manufactured by Farbenfabriken vorm. Friedr. Bayer & Co., Elberfeld, Germany (Continental Color and Chemical Co., New York).

ADNEPHRIN EMOLLIENT.

Recommended as a local application where prolonged use is required. Prepared by F. Stearns & Co., Detroit, Mich.

ADNEPHRIN OIL SPRAY.

The preparation is applied as a spray to the mucous membranes in congestive and inflammatory affections, preferably after washing with Dobell's solution. Prepared by F. Stearns & Co., Detroit, Mich.

ADNEPHRIN SOLUTION.

A sterile solution 1-1000 of the suprarenal active principle in physiologic salt solution containing one-half of one per cent. of methaform (chlorbutanol).

Actions and Uses.—The actions and uses of this preparation are described under Suprarenal Alkaloid. Dosage—The dose internally is from 0.2 to 2.0 Cc. (3 to 30 minims in water. Adnephren is also used in oily solution as a spray (See Adnephren Oil Spray), and in the form of ointment (See Adnephren Emollient). Prepared by F. Stearns & Co., Detroit, Mich.

ADRENALIN.

The active alkaloid of suprarenal gland, prepared by the method of Takamine (See Suprarenal Alkaloid).

Dosage.—Locally, 1-1000 to 1-15000 solution, as the chloride. Internally, 0.3 to 2 Cc. (5 to 30 mm.) of 1-1000 solution. Hypodermically, 1 to 15 drops of 1-1000 solution, diluted with sterile water. Manufactured by Parke, Davis & Co., Detroit, Mich.

ADRENALIN CHLORIDE SOLUTION.

Dosage.—See Adrenalin. Prepared by Parke, Davis & Co., Detroit, Mich.

ADRENALIN SUPPOSITORIES.

One part of Adrenalin to 1000 parts of oil of thebroma (cacao butter). Each suppository weighs about 1 Gm. (15 grains). Prepared by Parke, Davis & Co., Detroit, Mich.

AGURIN.

Agurin, $C_7H_7N_2O_2Na + NaC_2H_3O_2$, a double salt of sodium acetate and theobromine-sodium.

Actions and Uses.—It acts like theobromine over which it has the advantage of great solubility and that it is well tolerated by the stomach. While inferior in diuretic power to theophyllin (which see), it is said to have greater power in sustaining the diuresis produced. Dosage—0.5 to 1 Gm. (7 to 15 grains), preferably in wafers or capsules. If in solution, this should be freshly prepared (with peppermint water) and without sugar or mucilage. Manufactured by Farbenfabriken vorm. Friedr. Bayer & Co., Elberfeld, Germany (Continental Color & Chemical Co., New York).

AIROL.

Airol, $C_6H_5(OH)_3(COOBi(OH)) = C_7H_5O_6Bi$, a combination of bismuth oxyiodide (subiodide) and gallic acid.

Actions and Uses.—As it liberates iodine in the nascent state in the presence of wound secretions it has been recommended as a desirable and effi-

cient substitute for iodoform in the treatment of wounds, burns, skin diseases, gonorrhea, etc. Dosage—It is used externally in the pure state or diluted with talc, or in the form of a 10 per cent. suspension in equal parts of glycerin and water, or as a 10 to 20 per cent. ointment with 2 parts of petrolatum and 7 parts of wool fat. Manufactured by F. Hoffmann-LaRoche & Cie., Basle, Switzerland (The Hoffmann-LaRoche Chemical Works, New York).

ALPHA-EUCAINE HYDROCHLORIDE.

Alpha-eucaine hydrochloride is the hydrochloride of benzoyl-methyl-oxypiperidine-carbonic methyl ester.

Actions and Uses.—The action of alpha-eucaine is similar to that of cocaine, but it is regarded as three and three-fourths times less toxic than cocaine. In large doses it first stimulates and then paralyzes the central nervous system; it slows the heart and produces a fall of blood pressure. Locally it acts like cocaine as an anesthetic, but dilates the blood vessels instead of contracting them. It does not dilate the pupil. It is more irritating to the mucous membrane than cocaine or than beta-eucaine. It has a moderate bactericidal action. It is used as a substitute for cocaine in general and minor surgery, but beta-eucaine is preferred for applications to the eye. Dosage—2 to 5 or even 9 per cent. solutions. Not more than 2 Cc. (30 minims) of a 4 per cent. solution should be used at one time. Manufactured by Chemische Fabrik auf Actien, vorm. E. Schering, Berlin (Schering & Glatz, New York).

ALPHOZONE.

Alphozone, $(COOH.CH_2CH_2CO)_2 = C_8H_8O_8$, an organic peroxide resulting from the action of hydrogen dioxide or succinic anhydride.

Actions and Uses.—Alphozone belongs to the class of organic peroxides, and by its powerful oxidizing power becomes a germicide and antiseptic. Dosage—Alphozone is also marketed in the form of tablets containing, each 0.065 Gm. (one grain), of alphozone, which are used for making solutions, one tablet to 60 Cc. (2 fluid ounces) of water giving a solution (1 to 1000) suitable for general external use; but, as a nasal douche, one tablet in 180 Cc. (6 fluid ounces) of water is often preferred. Manufactured by F. Stearns & Co., Detroit, Mich.

ALUMNOL.

The aluminum salt of α -naphtholdisulphonic acid, $Al_2(C_{10}H_7OH.(SO_3)_2)_2 = Al_2C_{20}H_{14}O_{12}S_4$.

Actions and Uses.—It is an astringent and mild antiseptic. It is claimed that it can be used as a mild astringent, an irritant or a caustic, according to the strength of the solution, and it is asserted that it exerts a peculiarly destructive action on gonococci. It has been recommended for a variety of affections in which a caustic, astringent or antiseptic is indicated. It has been particularly recommended for gonorrhea in females, especially when affecting the endometrium. Dosage—As a surgical antiseptic, in 0.5 to 3 per cent. solutions; in gynecology, in 2 to 5 per cent. solutions; in otology and laryngology, either as powder or in $\frac{1}{4}$ to 1 per cent. solution as douches, washes or gargles; as cautery, in 10 to 20 per cent. solution. Manufactured by Farbwerke, vorm. Meister, Lucius & Bruening, Höchst a. M. (Victor Koechl & Co., New York).

AMINOFORM.

A name applied to Hexamethylenamina, U. S.

P. Sold by C. Bischoff & Co., New York.

ANESTHESIN.

Anesthesin, $C_8H_7(NH_2)(COOC_2H_5)_2$, 1:4 = $C_8H_{11}O_2N$ the ethyl ester of paramido-benzoic acid, obtained by the reduction of paranitrobenzoic acid.

Actions and Uses.—It is introduced as a substitute for cocaine, and is a local anesthetic, similar in its action to orthoform and said to be equally effective, but free from irritant action and toxicity. The anesthetic action, like that of the related compound orthoform, resembles that of cocaine, but is purely local, does not penetrate the mucous membranes, and in consequence of its insolubility the compound can not be used by hypodermic injection. In consequence of its insolubility the anesthetic effect is more prolonged than that of cocaine. It is recommended in various forms of gastralgia, in ulcer and cancer of the stomach for the relief of pain, and is applied locally in rhinologic and laryngeal affections, urethritis, etc.; it is also recommended for anesthetizing wounded surfaces, burns, ulcerations and painful affections of the skin. It is more effective in cases where the skin is broken. **Dosage.**—Internally, 0.3 to 0.5 Gm. (5 to 8 grains), in pastilles. Externally it is applied as a dusting powder, either pure or diluted. It may be applied as an ointment or in the form of suppositories. Manufactured by Farbwerke, vorm. Meister, Lucius & Bruening, Hoechst a. M. (Victor Koechl & Co., New York).

ANTIPYRINE SALICYLATE.

Antipyrine salicylate, $C_{11}H_{12}N_2O_5C_7H_7O_2COOH$ = $C_{18}H_{18}N_2O_8$, a weak chemical combination of antipyrine and salicylic acid.

Actions and Uses.—This compound possesses the properties of both antipyrine and salicylic acid and combines the analgesic power of the one with the anti-rheumatic action of the other. It has been used with good results in sciatica, rheumatic fevers, chronic rheumatism, influenza, pleurisy, dysmenorrhea, etc. **Dosage.**—0.3 to 2.0 Gm. (5 to 30 grains) in cachets or capsules.

ANTITHERMOLINE.

A name applied to a preparation said to be made according to the following formula: Each pound contains 4000 grains of imported washed kaolin, washed and purified, 14 grains boric acid, 14 grains oil of eucalyptus, menthol and thymol combined, and 4.9 fluid ounces of glycerin. It closely resembles the Cataplasma Kaolini, U. S. P. Prepared by G. W. Carnrick Co., New York.

ANTITHYROID PREPARATIONS.

Preparations obtained from the blood or milk of animals, after the removal of the thyroid glands. The use of these preparations is based on the theory that the thyroid gland secretes

products which are toxic, but which neutralize, and are neutralized by, other toxic substances produced elsewhere in the body. Removal of the thyroid glands, therefore, leads to the accumulation of these second toxic substances as evidenced by the phenomena of cachexia strumipriva and myxedema. On the other hand, the blood or milk of such animals is capable of preventing the effects of a hypersecretion of thyroid substance, such as is supposed to occur in Basedow's disease (exophthalmic goiter). These views are still largely hypothetical; but the majority of clinical observers report markedly beneficial results in the milder forms of the disease and in obscure nervous disorders which are supposedly connected with thyroid hypersecretion. The effects are less pronounced in the more severe forms. The action is merely palliative and other measures of treatment should not be neglected. Improvement occurs in two or three weeks and is indicated by an amelioration of the nervous symptoms, tremors, palpitation, insomnia and excitability. The administration must be long continued. Oral and hypodermic administration are equally effective but the former is usually preferred. These preparations are not toxic, even when very large doses (Cont. Color & Chem. Co.). Purgatin (Knoll & der (Fritzsche Bros.), Nov. 17, 1906. Protargol midon Salicylate (Koechl & Co.), Nov. 17, 1906. are used.

Book Reviews.

PRACTICAL DIETETICS, WITH REFERENCE TO DIET IN DISEASE. By Alida Frances Pattee, Fourth Edition. A. L. Pattee, Publisher, Mount Vernon, N. Y.—52 W. 39th St., New York.

This little book of 312 pages, price \$1.00, gives a short introduction on Food Values and Elements, general hints as to the care of the sick, and carefully tested and approved recipes for the preparation of various dishes required in sickness and convalescence. There are several chapters on diet in different diseases. A full index to recipes and contents completes the work. It will be of practical value to nurses, hospitals and all who have the care of invalids.

WOMAN IN GIRLHOOD—WIFEHOOD—MOTHERHOOD. By Myer Solis-Cohen, A. B., M. D., Instructor in Physical Diagnosis, University of Pennsylvania, etc., etc., Philadelphia. The John C. Winston Co.

Dr. Solis-Cohen needs no introduction to medical circles in this country, and his new book will be generally approved by physicians and meet a want long felt by women for whom it is especially written. It gives in language easily understood, valuable hints as to the preservation of health; it describes the ailments and troubles of women and treats of childbirth in a simple, practical way

The JOURNAL will be glad to print original papers from any source, preferably from members of the State Society, provided that they shall be of sufficient merit and shall be contributed to this paper exclusively.

Anonymous communications will not be published, but the name of the author of a communication will be kept secret if the editor is requested to do so.

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NEURASTHENIA, SOME TYPES AND THEIR MANAGEMENT.*

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That a group, rather than a single symptom complex, is embraced in the term neurasthenia, is a fact which is slowly being recognized. In the past we have been inclined to make the diagnosis without any definite investigation into many of the attendant phenomena and the picture obtained has been correspondingly one-sided and the method of management very definitely hazy. That is, we have been content, I fear, to merely ask a few questions, feel the pulse, look at the tongue and then dismiss the patient with a tonic and the caution to rest and not worry. But, even so cursory an examination as this would not be void of result, were we to observe the pulse carefully and the tongue understandingly, for an increase in the pulse tension and disorders of the gastro-intestinal tract are the most common and at the same time the least heeded symptoms of neurasthenia. Moreover, I am being more and more impressed with the importance of bringing out during a short conversation more than the obvious facts in the daily life of a patient.

A young woman presented herself at the clinic a short time ago carrying a well-developed, healthy looking baby of fourteen months and leading another small child by

the hand. She gave the usual history of a neurasthenia developing during the course of lactation. Nervous, emotional, sleepless, loss of strength, energy and power of initiative, distaste for the usual household duties and various pains and other sensations about the body. She volunteered the statement that she had been going to her doctor more or less regularly but could not now afford it as her husband was out of work and they were very poor. Among others, the following questions were asked:

How old is the baby? Fourteen months.

Are you still nursing it? Yes, sir.

Have you sufficient milk for it? No, sir; I feed it besides.

You should wean the baby at once if you want to get well. My doctor told me I should wait until after the hot weather.

When did you see your doctor last? About two weeks ago.

What did you consult him about? This awful nervousness and I couldn't sleep nights.

This conversation was followed by tearful protestations against weaning the baby when the hot weather was coming on. Her own health she totally disregarded, and her doctor apparently had no thought for the serious drain upon her vitality of the bouncing baby that she carried in her arms and fed at her breast. It was only after she was made to understand that in her present condition her milk was no longer the best food for the baby that she finally consented to wean it. She returned later, having weaned the baby, and already considerably improved. I mention this incident because it shows neglect to take cognizance of an obvious fact underlying and

* Read before the Morris County Medical Society, October, 1906.

responsible for this patient's condition and the failure to correct which caused treatment to be of no avail and the patient to seek help elsewhere.

The day has passed when the physical state can be regarded as one thing and the nervous state as another, quite distinct and separate. A condition of mind which approaches the nervous system as an evanescent, intangible, mysterious entity, inextricably enmeshed in a mass of material facts, of which, however, it is entirely independent, can hardly be conceived of in this era of practice of medicine and, it is hardly necessary to say, that such a hopelessly tangled state of mind is always a serious handicap to effective therapeutics. Now, the truth is always simple, always clarifying, always liberal. There is no realm of science in which the words of Christ regarding truth have a more appropriate application than in medicine. "The truth shall make you free," is a text for all time to science. Facts, facts and more facts is the constant cry of a hungry world, but I hold that a man should have sufficient imagination for the application of perfectly obvious facts and a little more imagination and often some courage in the grasp and application of new facts if he would in any degree succeed in medicine.

At the outset let us bear in mind two points of considerable importance. First, neurasthenia is a mental disease and the symptoms belonging to it and characteristic of it are mental throughout. Second, the gastro-intestinal disturbances, cardiac weakness and allied conditions are usually secondary. There are certain types of nervous affections which require to be differentiated from the neurasthenias; at the same time there is a large mass of clinical phenomena belonging exclusively to neurasthenia. In the former class we get many borderland conditions which at some time or other resemble neurasthenia more or less closely and one of these is paresis. To my mind one cannot make a more serious clinical error than to mistake the early signs of paresis for neurasthenia and yet this is a mistake not at all uncommon.

Such patients usually give a history of overwork and worry and anxiety; there is marked irritability, restlessness, sleeplessness, pains in the head and back, digestive disturbances, lassitude and lack of power of concentration. The patient may complain of the eyes and give a history of local parasethias or a sort of gastric crisis that should make us suspicious of a local arterio-

sclerosis. If, upon examination, there is a more or less well marked general arterio-sclerosis in a patient between the ages of twenty and forty, together with sluggish and unequal pupils and increased knee jerks, we may be very sure of our diagnosis of paresis. A history of syphilitic infection is obtainable in most all of these cases, and in not a few the patient will trip on the r's when asked to repeat test sentences.

The neurasthenic symptoms of the first stage of paresis may be looked upon as a sign of the arterio-sclerosis incident to and essential to this disease. When the arterio-sclerosis of syphilis becomes sufficiently severe as to give rise to nervous symptoms the case should not be regarded as neurasthenia but as incipient paresis and such nervous symptoms as irritability, lack of power of concentration, restlessness, defective memory, and lack of attention mean the involvement of the brain cortex and a condition always serious. Furthermore, the fact that brain workers who have had syphilis are very susceptible to paresis must not be lost sight of. It must be remembered further that no matter where or under what circumstances the above symptoms occur, they are mental symptoms. Irritability of temper and lack of attention are just as surely mental symptoms as the insane delusions and hallucinations.

There is another form of arterio-sclerosis that really gives rise to neurasthenia. I refer to the arterio-sclerosis of the gouty and those past middle life. A man past fifty-five who is obliged to work under considerable tension is especially liable to get into a neurasthenic state from which he will recover but slowly. There are some who do not recover but who get progressively worse in spite of everything we can do. These patients give a history of progressive emaciation, disturbances of digestion and assimilation, weak heart action and periods of weakness and sleeplessness. In addition, there is of course the lack of attention and power of concentration, irritability and fretfulness. The tongue is coated, the breath is foul, bowels constipated with marked gastro-intestinal fermentation. The circulatory and general nutritional disturbances are to be accounted for by the widespread sclerotic changes in the vascular tree, interfering seriously with the functions of the vital and digestive organs. There is great variation in the character and symptomatology of these cases; many give a history of not having been well for some time. Necessity has

seemed to require that the woman keep at her household affairs or that the man keep constantly at his work. Then the irksomeness of labor begins to show itself in the lack of power of concentration. The patient continues at labor until so much run down physically that an attack of vertigo or weakness gives the final warning of the absolute necessity of rest. Loss of weight in these cases is extreme. In a case of this type under my observation at the present time, there has been a loss of about forty pounds in ten months. In many instances the patient is so poorly nourished that one instinctively looks for the cause in some wasting affection like cancer or tuberculosis. Extreme weakness is evinced in a pulse lacking in volume and force. A very frequent pulse symptom and one of considerable importance, is the intermittent pulse. The heart skips an occasional beat; sometimes the interval is regular in its occurrence and sometimes it is irregular, giving rise to a corresponding interval in the pulse wave. This symptom is of special interest because of its alleged association, according to Engelmann, with an intestinal toxæmia. This theory is based upon data derived from observations regarding the behavior of the heart during experimental stimulation of the gastro-intestinal branches of the vagus. It is a very frequent symptom of neurasthenia particularly of the type associated with arterio-sclerosis.

The prognosis in these cases should be guarded and influenced greatly by the age of the patient and the degree of arterio-sclerosis. Recovery depends, I believe, almost entirely upon the ability of the nutritional disturbances to readjust themselves in accordance with the changes in the vascular tree. When the arterio-sclerosis is decided such a readjustment will take place more slowly and the conditions of rest and relief from tension should be all the more perfect in order to bring about the desired result. When the arterio-sclerosis is slight, of course such recovery may be expected relatively soon.

I want to say just a word regarding the neurasthenias occurring in the young or in the prime of life. I am always suspicious of hysteria or insanity when a mother comes to me with a tale of "nerves" in a child during adolescence. Cerebral exhaustion does not occur thus early unless precipitated by some exhausting process, such as disease or prolonged anxiety. Unrequited labor and care hardly figure thus early in life and this should be borne in mind, and

furthermore, the fact that the insanity of adolescence begins with nervous symptoms akin to chorea or neurasthenia, should be remembered. Any group of nervous symptoms developing in a child past fifteen years of age should make us think first of the insanity of adolescence.

There is a class of neurasthenias occurring between the ages of twenty-five and forty which are conditions of simple exhaustion and which readily recover under a regime of rest. These are simple exhausted mental states, brought about by overwork, coupled more or less intimately with worry and mental anxiety. More important for our purposes and from the standpoint of differential diagnosis, are those neurasthenias occurring at or near the climacteric and following childbirth or miscarriage. All these neurasthenic states resemble each other closely. The nutritional state of the patient is usually fairly good. The most important symptoms to the patient are those associated with the abdominal viscera. There is usually pronounced constipation or great irregularity of the bowels, associated with the discharge of hard fecal masses and distressing flatulence. Some of these patients complain of persistent nausea and pain in the epigastric and hypogastric regions. In some instances palpation in these regions will be found to be painful. These symptoms are evanescent and are unmistakable. The loss of appetite is absolute, but the patient will take food perfunctorily and is capable of digesting it properly.

A recent case of this type showed marked diminution of free and combined HC_1 . The motility of the stomach, however, was excellent. Another very common symptom is a jelly-like feeling, or a feeling of tremulousness throughout the abdominal organs. Almost all of these cases present a urine of high specific gravity, loaded with calcium oxalate crystals and many show indicanuria. In fact, the occurrence of calcium oxalate in the urine is almost a pathognomonic symptom in neurasthenia and one which I believe points decidedly to an intestinal toxæmia. It signifies especially that the processes of oxidation are incompletely performed in the gastro-intestinal tract and as a consequence the oxalates are eliminated in excess by way of the urine. I do not want to leave this portion of my subject without saying a word regarding the neurasthenic states following the artificially induced menopause, those nervous states seen especially following oophorectomy. Gynaecologists are no longer removing the entire

ovary in cases requiring the removal of the female generative organs, the great importance of the internal secretion of the ovaries for the maintenance of a state of healthy nutrition in women up to the age of fifty, being more fully realized. However, one still sees more or less recently operated cases which present the painful picture of the chronic neurasthenic doomed to a state of helpless invalidism. A case in point came under my observation a short time ago in the person of a woman whose ovaries and tubes were removed eight years ago. She has been a nervous wreck ever since the operation. From a slight woman weighing 120 pounds she has gradually taken on flesh until she now weighs 220, or 100 pounds more. Perspiring constantly and suffering from hot and cold flashes, she is weak, emotional and greatly depressed about herself. Having "suffered many things from many physicians," she is now a nervous wreck with no hope of relief from a burdensome condition.

In concluding this portion of my subject I desire to just mention the neurasthenic states following some of the acute diseases. It is not my intention to go into the nervous states that one expects during the usual course of convalescence from acute disease, but the depressed conditions following gripe are so frequent and pronounced that they deserve a place by themselves. The same is true of severe attacks of diphtheria in the adult. Of gripe I am inclined to think that it more frequently follows those severe cases in which there have been the usual gripe symptoms accompanied by gastro-intestinal disturbances. At any rate these symptoms, coupled with the subsequent marked neurasthenia, has made me feel the possible association of the gastro-intestinal symptoms with the involvement of the abdominal sympathetic. There is one other acute disease that I have seen followed by a marked attack of neurasthenia, and that is mumps. The case in question was that of a young woman who came home from college with an attack of mumps. She gave the usual symptoms for a day or two and then developed marked pain and tenderness in the ovarian region of both sides. These symptoms continued for several days and gradually subsided, the patient meantime becoming very nervous, irritable and exhausted. She became a very marked case of neurasthenia and presented, when I saw her, in addition to the usual symptoms, decided sensitiveness to light, sound and touch. She had lost flesh and strength, was in bed

continuously, taking but a small amount of nourishment and had a slight rise in temperature every evening. She was one of the most acute cases I have ever seen, but recovered slowly in the course of about six months under the proper regime. It is the only case I have ever seen following mumps. I believe it is to be associated with the involvement of the ovaries in the parenchymatous inflammatory process sometimes incident to this disease.

In the management of neurasthenia we shall find it necessary to individualize, especially as regards the mode of life of the patient. Not all cases do well on absolute rest; in fact, it has been my experience that comparatively few cases do well on the Weir Mitchell plan of treatment. I frequently have the patient remain in bed until noon, dine, rest afterward and then spend the remainder of the day up. Many other cases are allowed to rise at ten, rest for an hour after dinner and spend the remainder of the day out of bed. The amount of rest and the mode of resting depends entirely upon the degree of prostration (and the previous habits of the patient). Those cases past fifty years of age in which there is extreme prostration and in which the heart action lacks force and pulse lacks volume, will do best on a regime of continuous rest with a gradually increasing amount of exercise each day. In a few instances the institution of a graduated system of exercising, such as the Fraenkel system or the Nauheim system, will be found advantageous in initiating an exercise regime.

The matter of feeding is important. The principal meal should be taken in the middle of the day and the patient should always rest afterwards. A system of forced feeding will always be found advantageous. This is particularly true of those cases past middle life, in which there is almost no appetite and the patient feels disgust for food. Here the prescribing of a certain amount of milk every two or three hours is necessary. In all cases we can give a glass or two of milk between meals and at bedtime. To suit the taste or the digestion of the individual patient, we may modify the milk in various ways. Milk with an egg well beaten into it is well borne by some. To this may be added a tablespoonful of whiskey and a little sugar, which makes an acceptable milk punch. A few will prefer the egg and milk separately. Some do not digest the curds well; for these we may break up the curd by the use of lime water or a cereal gruel either dextrinized or plain. I

prefer the dextrinized gruel and use about one-third of a glass of gruel to two-thirds of milk. Peptonized milk, milk and vichy, milk and lime water, malted milk, will suggest themselves in those cases where assimilation is poor and where a variation in the form of milk is necessary.

Baths are always of value in neurasthenia and it is not necessary that the physician have at hand the facilities of a hydrotherapeutic establishment in order to administer them effectually. If there is a bath-tub with hot and cold water the facilities are sufficient; if to this is added a shower and spray they are ample for all purposes. If the patient shows considerable exhaustion we will do well to begin with a half bath which is given as follows: The tub is filled one-third full of water at a temperature of 98° to 100° . The patient sits in the bath and the nurse with a large dipper holding about four quarts, splashes the patient well, first in front and then on the back. The patient then lies down in the tub and the nurse rubs the extremities and chest and back well with the hands for about four minutes. The temperature of the water in the tub is then reduced 6° , 8° or 10° , depending upon the strength of the patient, and with this colder water he is given a final splashing in the same way as noted, and is then rubbed dry. The reaction following this form of bath is usually excellent; the rubbing with the warmer water prepares the patient for the reaction and the final splashing with the colder water completes it. I must not neglect to say that the patient's head must be wet with cold water and encircled in a wet towel. Patients usually like this bath very much. For some we may prescribe the regulation shower where it is available, or in stronger patients we may finish off the half bath with a cold shower. These bathing procedures should be done late in the morning or in the afternoon and the patient should be sent to bed immediately after for a nap.

Massage or vibration will be found of value in most cases, more especially those which present that very frequent symptom, spinal tenderness. In those cases mechanical vibration of one kind or another over the various spinal segments will give great comfort and relief. In lieu of anything better, a deep spinal rubbing by the nurse for fifteen or twenty minutes morning and evening will do great good. Best of all, if we have access to a static machine, we may educate the patient to the matter of having long sparks over the spine from one end to

the other for three or four minutes. These are usually very effective and give great relief from the feeling of pain and tension that the patient experiences in the back.

For the sleeplessness we shall have to resort to the temporary use of drugs in the majority of cases. The best in this condition I believe to be trional and it is not necessary to give more than fifteen grains, preceded by a hot bath and followed by a glass of hot milk. The bath should be of a temperature of 96° to 98° and the patient should lie in it quietly for eight or ten minutes and afterwards there should be no friction or rubbing of the skin. The patient should be dried quickly and retire at once.

I need not dwell upon the drug treatment of this condition. For myself, I rely chiefly upon some preparation of iron for its tonic effect. One of the most annoying symptoms of neurasthenia is the great flatulence often associated with a chronic colitis. When this condition is also associated, as it often is, with oxalates or uric acid in the urine, I am accustomed to prescribe the daily use of a high enema until these products disappear. I also give a purge of calomel or blue mass twice a week followed by a saline; five grains of blue mass may be given at night and the saline the following morning one-half hour before breakfast. For the gaseous eructations we may give a capsule containing zinc sulphocarbolate, one-half grain, and bismuth subnitrate three to five grains. A favorite capsule with me is Strontium salicylate two grains, phenol bismuth one grain, sodium benzoate two grains. One or two an hour after meals. It will be found that this line of medication will improve the condition of the gastro-intestinal tract, clearing up the tongue and relieving the foul breath.

The mental therapeutics of neurasthenia are of the greatest importance. In fact, there is no field in medicine where the physician himself, his personality, his character, are of such importance and of such weight, in a therapeutic sense, as in these nervous conditions. These patients watch you intently; the expression of your face; what you say; what you do, and what you are, are of the greatest moment and they receive hope or are more depressed depending upon a smile or an unguarded look of gravity. Patience and tact must never slip from you; firmness, yet with sympathy, must be ever present; for we shall often need all of these in order to draw the patient out of him or herself and put them upon a higher footing. Fear and selfishness are the two elements

which we are called upon to combat most. Some one has characterized ignorance as the only crime. In the same meaning, my experience with these cases has been such that I am almost tempted to characterize fear as the only disease. Fear of the variations in temperature; of the effects of eating and drinking, of sleeping and not sleeping, of fair weather and bad, of sunshine and darkness, of noise and quiet, of company and solitude, of work and of idleness. The creed of the neurasthenic is full to overflowing with these and similar fears, more or less trivial in character yet real to him, out of which he must be led by the tact and personality of the physician. The mind of the patient is so introspective, so turned inward upon self, that we find him analyzing and observing his own symptoms, imaginary and real, magnifying them out of all proportion to their real value. The feeling of the pulse often becomes a favorite occupation and also the observation of the tongue, and the slightest variation in the pulse rhythm, or a coated tongue, is most carefully noted and duly expatiated upon. Yet, the absurdity of such proceedings must be presented to the patient in a rational manner.

And, finally, the selfishness of the patient is a mental characteristic which can often be traced to the peculiarly commanding position which the invalid invariably occupies in the household. So far as the physician is concerned, these conditions must be met without passion, for the loss of one's temper means the loss of prestige and control which, in the treatment of these conditions, means everything. Frankness, directness of speech to and with the patient, reinforced by directions to the members of the household, usually have weight and the patient is always better off when he comes to realize that there is some one else in the world besides himself. In fact, the re-education and readjustment of the patient to more or less new conditions is the watchword in the mental therapeutics of neurasthenia.

"Whichever may be the primary cause of arterio-sclerosis, certain is it that any treatment of the condition to be successful, must aim to diminish the high blood pressure. This can be accomplished well by thyroid extract in small doses if we believe there is evidence of diminished thyroid secretion, and it must be remembered that any small dosage of iodine or iodides will stimulate the thyroid gland to greater activity, and hence the long known value of this drug in arterio-sclerosis."—Dr. O. T. Osborne (*New York Medical Journal*).

TETANUS.*

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In presenting a paper to this Society I chose a subject upon which all could speak, as the disease upon which I formed this attempt is one which we may meet or have met in our various lines of work—one which affronts the physician and surgeon alike. The subject of my paper is Tetanus.

Tetanus (its name being derived from the Greek word *tetanos*, to bend, to twist) is an infectious disease, invariably of microbic origin, generally traumatic, characterized by persistent tonic spasm, with violent brief exacerbations. The disease is either acute, subacute or chronic. This condition is by no means new, as it has been known for centuries—Artaeus was one of the first to describe it and in his account gave causes which are to-day still held accountable clinically, such as wounds, blows, burns and abortions in women; but his claim that women were more susceptible to the infection than men of course is not true to-day—yet this point may have been true in his day, as women may have been placed in positions which would make them prone to the disease.

Although known by Artaeus, a clear insight into the disease was not reached until the time of and through the instrumentality of Ambrose Paré. This clearer conception of the condition arose at this time when surgery assumed a more important position, and tetanus most frequently presented itself as an accidental surgical disease. With the introduction of firearms in warfare there was gradually developed a surgery of war. (Military surgery): hence most of the literature came from military surgeons.

AGE. Tetanus is confined to no one period of life, and no period of life is exempt except between the first month and the fifth year of age, during which time there is almost complete exemption. Between the years of ten and twenty it occurs with more frequency than any other age—75 per cent. of all cases occur between the ages of ten and forty years; after the fourth decade the disease is found with decreasing frequency. This percentage has been sustained in New Jersey for a period of five years. In the United States 1900-1904, there were 6,072

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deaths from tetanus—5,582 of which were below forty-five—490 above, or 91.9 per cent, below forty-five. Yandall cites a case of tetanus at the age of eighty-nine years.

SEX. It has been found that more males die of the disease than females, which according to Gower is about six to one, except in infants where the number of cases among males and females are about equal. This is also borne out by the New Jersey statistics for five years. The fact that more men die of the disease than women is not one to be deeply considered, as the male adult is placed in occupations and positions to become infected more readily than the female. In equine races more stallions die than geldings, more geldings than mares.

RACE. It is claimed that the darker races meet with greater ravages by this infection, yet the Arabians enjoy immunity according to the French surgeons, and there are places North where the white races suffer to almost extermination. In India it was claimed that the Jews suffered in greater numbers than either the Christians or Mohamedans; but after fuller investigation it was proven that it was only so on account of the Jew undergoing circumcision, hence were open to infection while his Christian brothers were not. This was exemplified by the fact that all of the cases occurred during the third or fourth week of life. In New Jersey for a period of five years more whites died than blacks. In the Civil War sixteen cases occurred in the colored race out of a total of 505 cases, or 3.1 per cent. The colored race furnished but 2,790 of total number of injuries.

LATITUDE. Latitude is considered a predisposing cause. The Tropics have been the scene of the greatest outbreaks of the disease, especially types of puerperal and neonatorum tetanus. In Bombay 232 cases occurred in three years.

Peat gives a table appended of acute tetanus in Bombay: Out of 11,929 natives, 161 cases, or 1.3 per cent.; out of 2,733 Europeans, 21 cases, or .77 per cent. In Iceland it is hardly known, yet in the island of Heimaly, off its coast, the population would have died out if it were not for immigration, as all children born there died of the disease. For years St. Hilda, New Hebrides, has been scourged by the "eight day sickness." Eighty-four out of one hundred and twenty-five children born died of it in the first fourteen days of life. But since the discovery of its cause philanthropic people of Scotland sent a trained nurse there who taught the midwives the antiseptic care of

the cord and the disease has now entirely disappeared from the island.

OCCUPATION. Although looked upon as a predisposing factor, I believe that occupation has very little bearing on the disease; yet it has been claimed that men who attend to stables, horses or work in agricultural lines seem to be peculiarly exposed to an attack of the infection. Pizzini examined the feces of ten grooms and found the bacillus of tetanus in three cases, where the feces of ninety peasants who did not come in contact with horses only two gave positive results. Although it is claimed that the bacillus thrives in manure, in stables, and that grooms are more often attacked, the terrible outbreaks in the New Hebrides occurred for years where there are no horses. In the United States, 1900-1904, the average death rate for tetanus per 100,000 population in cities was 12.6 and in the rural districts 9.4, thus contradicting a widespread belief that the disease is more prevalent amongst agriculturists and in rural districts.

HEALTH. Gower does not look upon previous health as a pre-causative factor as the rugged seem more liable than the weak or sickly, possibly again this is due to the fact that the weak or sickly do not place themselves in occupations or positions which cause them to become infected.

METEOROLOGICAL CHANGES. Changes in temperature from hot to cold seem to have in the past been associated with greater outbreaks of the disease. Examples of this were shown during the Siege of Prague, when 1,000 cases occurred on the field of battle amongst those left unsheltered and exposed. At Strausburg, Poncet did not see a single case of tetanus during the early season of the siege, but in the fall a dozen cases or more occurred in the military hospital.

FREQUENCY. Tetanus in the temperate zone is comparatively an infrequent disease, being met in only a small proportion of cases, except where it sometimes becomes endemic. In thirty-two years 113,020 patients were treated at Guy's Hospital, London, of which seventy-two were cases of tetanus—one case to 1,570 patients. In comparison with the whole number of deaths, the deaths from tetanus in Guy's Hospital for a period of five years amounted to an average of .056 per cent. In London to .0025 per cent., and in the whole of England to .0031 per cent. In the Vienna General Hospital, from 1855 to 1864, among 239,911 patients, fifty cases of tetanus occurred, or

one to 4,798 patients. Rose reports that in the Bethanien Hospital of Berlin, during the years 1847 to 1864, .08 per cent. of all patients died of the disease. In Berlin in 1867, out of 683,673 inhabitants, 275 died of tetanus; i. e. .04 per cent. of the entire population. In the Civil War, out of 246,712 injuries by weapons of war, there were 505 cases of tetanus, or 2 per 1,000 cases of injury. In the entire United States for a period of four years the average deaths from tetanus per 100,000 population were 3.8.

NEW JERSEY. In 1900-1904 there were 136,776 deaths, of which were 392 from tetanus, or .023 per cent. From the New Jersey State Board of Health Reports for 1905 there were 35,398 deaths in one year in this State, of which sixty-six died of tetanus, or .018 per cent., and for a like period of four years in New York .011 per cent. of the death rate. The above statistics show the variability of the disease at different places and times.

PROGNOSIS. The prognosis is very grave, and depends upon the length of time of the period of incubation; if it is short it is almost always fatal. Rose and Carless from a great number of cases, have formulated a table of recoveries: If the period of incubation is 10 days, 4 per cent. recover; if the period of incubation is 15 days, 27 per cent. recover; if the period of incubation is 20 days, 45 per cent. recover.

I have seen seven cases of tetanus in which the period of incubation was under six days and every one was a fatal case. Authors vary in mortality and I think mortality should be considered very carefully so that the value of the newer treatment can be found in comparison with the old or sedative treatment. Below I will quote several mortality lists which are those prior to use of antitoxin:

Curling, 128 cases, 70 deaths, 54.2 per cent.; Frederick, 252 cases, 128 deaths, 50 $\frac{3}{4}$ per cent.; Demme, 86 cases, 80 deaths, 93 per cent., which makes 66 1-16 per cent. mortality. The mortality of the Civil War was 505 cases with 451 deaths, or 89.3 per cent. The mortality after the discovery of antitoxin I shall discuss under the caption of treatment. Another determining factor in prognosis is temperature, as any sudden rise in temperature signifies a bad foreboding.

CLINICAL CAUSES. Although the disease has in the past been subdivided into various types, namely, traumatic, idiopathic, puerperal and neonatorum, yet from the more modern study, and hence intelligent under-

standing of its cause, it should only be considered under the type of traumatic, as in all cases there must be some injury; i. e. a solution in the continuity of structure, either apparent or concealed, which becomes infected with the tetanus bacillus. Apparent injuries make the cause obvious, but injuries concealed sometimes enshroud the cause in mystery; examples of such are: (a) Inhalation of dust causing intravascular infection of wounded tissues around a simple fracture; (b) That slaves died of tetanus after having eaten the flesh of a bull dead of the disease.

Even some of the apparent traumatic cases seem almost incredulous, such as floggings, burns, extraction of teeth, frost bites, foreign bodies in eye, and tetanus caused by cobwebs applied to a wound to stop hemorrhage.

It is apropos at this time to speak of the character of wounds which usually become infected by the bacillus. It has been found that any wound is liable to infection, but punctured wounds, especially rapidly healing wounds, the depths of which are not exposed to the air, such as bullet wounds, penetrating wounds and wounds produced by implements which have been in contact with the soil, manure, hay, earth or masonry and also wounds which have shattered nerve trunks, are those peculiarly prone—whether from the fact that most wounds occur in the extremities of the human being or whether tetanus selects wounds situated thus is an open question, yet the former claim is, I think, the correct one.

Thambayn gives a table from 395 cases, the most probable seats of injury: Hand, 111; leg, 97; foot, 87; head, 44; arm, 31; trunk, 25. In our Civil War, out of 505 cases, there were: Head, 21; trunk, 55; upper extremities, 137; lower extremities, 292.

BACTERIOLOGY. The causes of tetanus were merely problematic, and left the surgeons groping in a wilderness of uncertainty until Sternberg, in 1880, awakened the entire medical world to enlightenment. In this year he produced experimental tetanus in rabbits by injecting under the skin, gutter mud from the streets of New Orleans, thus proving its transmission and hence stimulating research for the then unknown cause—the tetanus bacillus.

Not until four years had elapsed did Carle and Rathbone first show that the disease could be communicated to lower animals from man—rabbits, inoculated with pus of a case in man developed the disease and

gave it to others. Following closely in 1885 Nickolier inoculated rabbits and mice with dust and earth and at last found the specific bacillus in the pus at the seat of inoculation. To complete these scientific investigations Kitasato in 1889 announced, that, after laborious research, he had isolated the specific bacillus in pure culture and during his investigations had found three important characteristics in its growth which were important in guiding the treatment and prophylaxis of the disease. These findings were: (1) That the bacillus was spore bearing; (2) That the spores were resistant to heat; (3) That oxygen was inimical to the growth and development of the bacillus.

The last feature is one which gave the investigators considerable difficulty in isolating the bacillus on culture; as any oxygen being present prevented the growth, hence they were grown under hydrogen which seemed to increase their growth. The one feature of the bacillus is the almost indestructibility of its spore. This resistance is also true in its power to withstand germicides, thus Sternberg found that they will resist 5 per cent. carbolic acid solution for ten hours, 1-1000 bichloride for three hours, but 1-1000 bichloride with 0.5 per cent. H.C.L. added will kill the spores in thirty minutes. The bacillus itself is a slender microorganism with its spore attached to its end, making it appear like a drum-stick. It liquifies gelatine, is mobile, is anaerobic, that is, will not grow in the presence of the slightest amount of oxygen. This is one point which seems to contradict itself; because the bacillus grows in the upper layers of soil, in loam, in hay, manure, and upon rusty and dirty implements, etc. This argument is met by the statement of bacteriologists that its growth in these positions is possibly due to the fact that the infection is nearly always a mixed one, and that some other bacillus accompanies it and absorbs the oxygen, and thus makes the soil suitable for its development.

At this point it is well to consider its peculiar position in causing the symptoms in the animal when once implanted in suitable environment. The bacillus does not migrate through the blood stream, as in the blood the oxy-haemoglobin, which is rich in oxygen, would destroy it, but it produces toxins, three in number, namely, tatanin, tetano-toxin and spasco-toxin, which cause the symptoms and which are present in the blood. These poisons are looked upon as the most powerful known and considered to be toxalbumins.

Brieger and Cohn discovered that .000-00005 gm. was surely fatal to a mouse weighing 15 gms. When this poison is compared to three other most deadly poisons its strength can be appreciated. As an example it takes to kill a man 175 pounds: .00437 gram of carbo venim, .130 grams of atropine, .03. gram of strychnine, but only .00023 gram of toxalbumin of tetanus to kill a man of 175 pounds.

PATHOLOGY. The pathology of tetanus is not at all distinctive. There is usually hyperaemia of the cord and brain, and if the patient dies in spasm we are more likely to find extravasations of blood and in rare instances rupture of tendons and muscles due to tetanic convulsions. The amount of congestion depends upon the mode of death, as when the patient dies of exhaustion extravasations and hemorrhages are apt to be absent. Post mortem temperature is also found, which I found true in one case after death in which the temperature rose one degree in ten minutes from 107° to 108°. Another interesting, yet unimportant, fact is that rigor mortis is very rapid, in some cases coming on immediately.

SYMPTOMS. It is hardly necessary to dwell upon the symptoms of tetanus, as when once witnessed it is never forgotten, as it is really alone in its typical set of symptoms. The attack is gradual, with a history of a wound, beginning with a chill usually, or the chart shows a sudden rise in temperature. In but a few hours stiffness of the neck or jaw appears which deepens as time passes; this one symptom when seen early in a case, where an injury has occurred, as the subsequent symptoms follow with such rapidity that they are upon the victim before he can appreciate his dire condition; soon to follow occur stiffness of extremities, back and abdomen. This condition increases each hour until opisthotonos, pleurosthotonos, or emprosthotonos occurs. Closely upon their heels come convulsions which vary in number from one in an hour to one in every half minute. One case which I saw had ninety convulsions in a period of six hours, or an average of one per four minutes. During this interval the face becomes distorted into a sardonic smile, called risus sardonicus, due to tetanic contraction of muscles. The temperature ranges from 100° to 105°, the pulse is quickened and death comes upon the sufferer either from exhaustion or asphyxiation. All through this group of symptoms the patient lies absolutely fearless, not for

one moment thinking himself in the grip of a fatal disease.

TREATMENT. Knowing the great virulence of the toxalbumins of tetanus, the rapidity with which they act, that the bacillus remains at the site of the wound and manufactures its toxins there and through the blood stream distributes them to all parts of the body, especially selecting the central nervous system, large nerve trunks and voluntary musculature, we have an array of tangible facts which should lead us toward the proper care of the case, at least theoretically if not entirely practically. Paramount in the treatment is prophylaxis; any suspicious wound should be opened up immediately, thoroughly curetted if possible and an antiseptic applied to destroy the bacillus and its spores. From bacteriological tests the most destructive germicide is a solution of bichloride of mercury 1-1000 with .5 per cent. H.C.L. added, or a strong solution of iodine which has the advantage of extreme penetration.

The result of treatment is directly proportionate to the lapse of time between the first implantation of the germ and the time treatment is begun; the rapidity varies in cases. One case which I saw was a case of gunshot wound in which the patient was so shocked that immediate amputation could not be performed and a lapse of twelve hours supervened, but this procrastination cost the patient his life, as tetanic symptoms occurred on the sixth day from the time of his injury in spite of amputation and subsequent treatment.

In view of the fact that once the infection has gained great headway any treatment is usually futile, all patients having received suspicious wounds should receive an immunizing dosage of antitetanic serum of about ten to twenty c.c. Dr. McFarland in a paper states that ten per cent. of horses used in making the antitoxin died of tetanus previous to a routine practice of immunizing each animal every three months with antitoxin. Since this procedure tetanus has entirely disappeared from the stables where they were kept, showing that an ounce of prevention is worth a pound of cure. Dr. H. J. Sherek, of St. Louis, Mo., reports that in 1903 there were fifty-six Fourth of July injuries reported in St. Louis dispensaries, out of which sixteen cases of tetanus developed, and in these cases antitoxin was not used as a preventive, but that for 1904, 1905 and 1906 there were 290 cases of similar injuries reported and in all of which

antitoxin as a preventive was used and not one case of tetanus developed.

Bazy, of France, after having four fatal cases of tetanus in one year—since which time he has used the serum as a preventive in all cases of suspicious wounds—has not had a case of tetanus to occur except in one instance where it was accidentally omitted.

Before passing from the local treatment I will pause to mention a unique and theoretical mode of local treatment, practiced by Dr. Strock in Cooper Hospital which consisted in oxygenating the original wound by forcing oxygen gas by means of drainage tubing into the site of the injury. Although this procedure failed to save the patient from tetanic symptoms its failure cannot be taken too seriously, as it was performed by means of an improvised apparatus and was not begun until the disease was well developed. This method is entirely original and seems plausible, being based on a bacteriological fact and cannot be judged until after a fair test at the onset of the disease.

Our efforts in the systemic treatment must be directed toward three important goals: First, controlling spasm; second, support of patient until the toxins are eliminated or neutralized; third, overcoming the toxins by neutralizing. Sedatives have been used for decades for the control of the spasms, especially those drugs which depress the motor nerves, namely, physostigma and its alkaloids—eserine, potassium bromide, chloral, curara, and finally anaesthesia by means of chloroform. From these I have only seen chloral and chloroform give good results. The danger in using these strong depressors lies in their depressing effect upon the circulation and respiration. Chloral is best administered by rectum, as usually any attempt to give medicine by mouth excites the patient into a convulsion which increases the trismus, thus preventing its proper administration. Eserine and curara, although once considered valuable drugs, have now become derelicts. Having seen eserine used in three cases, I can give it no compliment. To control the spasm temporarily chloroform is without doubt the best, and is indeed a solace to the patient in his last hours which are extremely harassing to both patient and attendants.

In considering the support of the patient little can be said, as this is the most difficult end to meet, usually in an ordinarily severe case, the only means lies in the use of hypodermic injections of cardiac stimu-

lants, namely: digitalis, atropine, nitroglycerin, adrenalin, whiskey and caffeine, and morphine for pain. Strychnine, although a good stimulant, cannot be given without risk of increasing the convulsions and therefore is contra-indicated. Feeding is a part of this division of treatment which deserves mention, as in endeavoring to administer food to a tetanic victim we meet with great difficulty. It is generally advised to feed patients by means of a stomach-tube, but I feel this is a dangerous procedure, as in cases where there is marked trismus it requires the extraction of two or three teeth for the proper introduction of the tube. In one case which I treated at Cooper Hospital under the advise of my chief, I administered milk and eggs by means of a stomach tube and while the tube was in position there occurred a cramped spasm and the patient was immediately asphyxiated—due to the oesophagus closing on the tube and pressing on the trachea; this case shows the great advantage of rectal alimentation over stomach feeding as a routine. The best foods for rectal feeding are milk, eggs, bovine, liquid peptonoids, panopepton and de-fibrinated blood; small amounts to avoid rectal irritability frequently administered are to be advised.

„For neutralizing the toxins many special treatments have been used, important among which is the Bacelli treatment, or carbolic acid treatment, consisting in subcutaneous injections of a 2 per cent. carbolic acid solution at two or four hours intervals in such quantities that not less than three grains per day are used. Good results have been claimed for it in Italy, yet it is known that in that country the disease is not virulent. Another special mode of treatment is the saline infusion, commonly termed cell catharsis or diuresis, propounded by Matthew and Loeb, which has for its objects the cleansing of the toxins from the cellular tissue by means of salt solution. Although this was found practicable in animals it failed to give gratifying results in man. Last and indeed the most important and most successful treatment is that by means of curative serum or antitoxin. To Behring, Tizzoni and Kitasato may be given the credit of this discovery. It is based on the fact that the blood serum of animals artificially immunized to tetanus contained a body which when the serum was mixed with a virulent culture of the tetanus bacillus destroyed the virulence of the cultures for susceptible animals. Hence if equal parts of serum of immunized animal and a fatal dose

of tetanus toxin are injected into a healthy guinea pig tetanus will not follow, showing that the virus is neutralized. Facts to prove the efficacy of antitoxin treatment are to be sought by every physician and surgeon, and should be cherished, as statistics on the subject are very meager and differ somewhat with various writers.

Although there are differences to a slight degree in the mortality tables, yet the consensus of opinion is that the mortality in this disease has been reduced. No less authorities than Hare and Roswell Park claim a reduction in the death rate of 50 per cent. Without the use of antitoxin treatment the mortality varies between 70 per cent. and 90 per cent., usually considered to be 80 per cent. Packard and Wilson gathered together 1,216 cases of tetanus treated with antitoxin giving a mortality of 42 per cent. Moschowitz found in 461 non-selected cases treated with antitoxin, amongst which there were advanced cases, a mortality of 40.3 per cent. Lambert found 30 per cent. mortality in a large number of cases treated with antitoxin. Goodrich has found in 113 cases treated with antitoxin a mortality of 37 per cent.

From a list of many cases treated at Cooper Hospital there were only three cases saved and upon these cases antitoxin was used. These cases were treated by Drs. Strock and Nicholson respectively. There are three methods for the use of antitoxin, i. e. subcutaneous, intra cerebral or subarachnoid, and intravenous. The subcutaneous and intravenous are considered the most efficient, as intra cerebral or subarachnoid injections both complicate and prolong the procedure and have not given results comparable to the other two methods. In deciding the efficacy of any mode of treatment we must draw conclusions from the results and in this disease the mortality lists are the convincing argument. Previous to antitoxin the average mortality was 80 per cent., and now with its use it is approximately 40 per cent., which shows a reduction of 40 per cent. in the death rate. In closing I will not argue for either treatment, but will leave the case for my fellow-physicians to decide which mode gives the best results, which I hope I have made obvious.

Slaughter Houses Closed.—As the result of the investigation by the Board of Health, the condition of Philadelphia's slaughter houses, 37 out of 171 inspected were ordered closed on the ground of being general nuisances, inimical to public health.

THE MEDICAL MAN IN POLITICS FOR THE PUBLIC GOOD.*

By Luther M. Halsey, M. D.,
Williamston, N. J.

It seems to me an opportune time to express my appreciation to the members of this Society for the cordial support given the Committee on Legislation. In legislative matters we are in somewhat of a chaotic condition; far from my ideal as to what it might and should be, and that we do not occupy the high plane in legislation which of right belongs to us. Much has been accomplished, and Burlington county has ably assisted in the work. I shall attempt as briefly as possible to give you my conception of the position the medical man should occupy in politics, his duty to his County Society, his state and the public at large. There never was a time when real men were needed more than now. The need is for more men in public affairs influenced alone by the public good, and fewer of those who are in it for revenue only. It is a mistake to suppose that one must hold public office to serve his country. It is just as essential to good government for private citizens to discharge the duties resting upon them, as it is for officials to carry out faithfully their obligations in the public service. For the greatest obstacle in the way of good government movement—which represents the best there is—is the inactivity of good citizens and doctors are large factors in this class.

As is true in the history of all problems involving questions of public welfare, the history of medical legislation is replete with bitter battles waged between contending forces. It is, however, specially interesting to study the nature of the forces influencing medical legislation, because we find them so different from what we would naturally expect. For the purpose of consideration, they may be classified after the true Hibernian method, viz: for and against. Among the former we should expect to see the desire upon the part of the people to protect themselves against incompetency, quackery and all that those terms embrace, the strongest factor in the enactment of these statutes. But in no instance can it be asserted that the people have ever taken the lead or shown the least interest in the enactment of a medical law. On the other hand, we find that

it has been the medical profession who have taken the initiative in securing the passage of these laws, primarily intended for the protection of the public health, and beneficial to the profession only in an indirect way. The fact that medical men have been so earnest, unselfish and persistent in their support of these laws, in the face of the apathy and indifference manifested by the people, has always militated against successful medical legislation, because it is difficult to establish the fact with many persons, especially members of our Legislature, that there exists in the heart of man such a thing as a desire to labor for principle.

Our efforts, however, have been to a great extent poorly generalised, disconcerted and spasmodic in character with no definite plan for action common to any two States, and frequently in the same State we find each succeeding Legislative Committee totally disregarding the work and plans of its predecessor. They discover too late that they would have been more successful had they profited by the experience of those who had gone before them. What the profession needs, and must have before there can be uniform ideas regarding medical legislation and concerted, definite plan of action, is to have some deliberative meeting, discuss and agree upon the proper principles underlying the several essential features of a medical law. Such a body should be made up of at least one representative from each State and Territory and the federal district, and should hold a session of several days, in which time they could agree upon the essential features of a model law, and adopt a plan of action to be recommended to the several state committees. An attempt to secure such a model act was made at the National Legislative Council two years ago, but, owing to the necessity of carrying on their labors by correspondence among the members of the committee, it failed to accomplish anything. For the same reason so many of our American Medical Association committees which meet for a few moments during the annual session, seldom with a majority present, and frequently do not meet at all, fail to achieve aught toward the purpose for which they were appointed. It takes time and deliberate thought to accomplish anything along these lines, and the sooner the profession realizes the necessity of tackling these problems in the proper manner, the sooner we may expect success to crown our efforts.

The most potent force that influences medical legislation adversely, and one for

* Read before the Burlington County Medical Society, January 9, 1907.

which the profession have themselves to blame, is the profound apathy and indifference the majority of its members manifest in matters pertaining to the enactment, or amending, of these statutes. With unwarranted school dissensions and this apathy on the part of the profession, how can we expect a few enthusiastic members to cope with the solid front. Nothing strengthens a man in his chances of winning a contest more than to realize his own shortcomings. We as a profession should recognize the danger of becoming narrow-minded and autocratic through the conditions peculiar to our work, and do all in our power toward the development of the broad spirit of freemasonry, liberality and consideration of the opinions of others.

But is the attitude of our profession toward the people in this State all that we should make it? Does the organization for the foundation of which some of our members have worked so hard and so faithfully really amount to what it should, by virtue of its numbers and the standing of its individual members? Are we doing all of that work which it is ours, by reason of our choice of life-calling, to do? We have numbers, machinery and means of publicity; but have we given an expression of that potential strength which should be in us? Are we working for the general public welfare together, harmoniously, intelligently, as we should work, by virtue of that same potential strength which is, or should be, in us; or are we still acting as an incoherent mass of units, ignoring much of the duty we have placed upon ourselves? These are questions which each one of us should take home to himself, and consider them honestly and truthfully. Is the spirit of charity and brotherly love, of harmony and study, actuating the individual members of our many County Societies? Does the County Society mean to you what it should mean—the place where all meet for the betterment and improvement of all, and the increasing of the sum total of medical knowledge; the place where prejudices are laid down and forgotten and needless enmities sloughed; the place where friendships are to be made and cemented through intercourse and mutual understanding? Does it mean to you a power for the public good and a means for exercising that care for the public, in general health matters, and that protection from its sins of ignorance, which it is the duty of our profession to exercise?

We do not have to search for civic and

professional duties to perform, nor for ways in which the potential strength which is in us should be brought out and directed. The people need guiding, educating, protecting; and it is through our societies and the individual members of them that this strength of our profession should be made manifest. We see charlatans on every hand, not injuring physicians, but deluding and robbing the sick and unfortunate and preying upon the defenseless. Graft is but a concrete expression of that fundamental characteristic of human nature, a desire to get something for nothing. We see it on every hand and we, as thoughtful physicians, realize that in every instance it is the poor man who pays the graft bill. Is it not one portion of our duty to preach honesty and thrift as we pass through life? We see men whose every instinct is only pure commercialism, grow rich from the brains and dollars of physicians whose training and instincts are for professionalism! Should not our organizations act for the benefit of all and exert some potential strength in the curtailment of this fattening process? We see some of this class defrauding the public, through our unintentional assistance, by coining a few cents worth of drugs, and a good many lies, into some wonderful nostrum. Is it not our duty to put a stop to this form of dishonesty by educating ourselves and the public and demanding the truth? We see criminally rich and convicted corporations determining the pittance which they will pay the members of our profession for our work. Is there not ample opportunity here for an exercise of our potential energy? We, see alas! some of our own members, foolishly trading away their professional heritage of self-respect and feeding upon a mess of contract pottage. Is there not room here for charitable education, for kindly persuasion and argument, for right precept and example, that he who has done a foolish thing may see his folly and abjure it?

As individuals we can do much for civic betterment if we will do each his duty to the community in which he lives, giving some portion of his time for the benefit, not alone of his fellow-man, but incidentally of himself; for municipal and State honesty profit every citizen in the commonwealth. But we can do more as an organized body of intelligent citizens working harmoniously for the common good than we may as individuals. Therefore, it is one of the most important of our duties as individuals to cultivate and make strong our societies—our

organizations—and to develop to the uttermost the proper expression of that strength for the public good which we have concealed within us. Merely as individuals divided, ununited, ignorant of each other's ideas or efforts and of what is being attempted, we could do little to protect the public from pretenders to medical knowledge. As a united and actively organized profession, suggesting, educating, advising, in short, taking our rightful place in the legislative activity of the State, we can do much. But we must often work most unselfishly. Sometimes it will be our convenience or our pleasure which must yield to the public good; sometimes our own personal likes or dislikes must go; and again, a personal prejudice must be overcome. But you cannot get something for nothing. We cannot do our plain duty to ourselves and the public unless something in the way of time and personal effort is given by us. And the giving must be unselfish; without thought of personal gain.

We should earnestly strive for organization, fellowship, charity, brotherly love and devotion to the public good as well as to professional betterment. Some societies there are, to be sure, which are good, live societies; whose meetings are frequent and well attended; whose members are active for the general welfare. But is this true of all? Do you yourself think that you are doing all your duty to yourself, your community and your fellow-physicians? Are you attending your County Society as you should and participating in its work as it is your duty to do? How can we ask the public, or our legislators, to agree with us when we do not agree with each other and do not act jointly and as harmonious units of a great organization? And how can we act together if we do not come together and understand each other? Lack of interest in society work means lack of interest in professional advancement and individual improvement, and that means a poorer class of doctors than the patients are entitled to, and sooner or later the community will find it out. In union, peace, harmony and industry, are advancement, public health protection and public welfare. In apathy, antagonism and indifference there is no professional progress, no guarding of the public against what we, as educated men, know to be frauds. Shall we devote our energies to the perfecting of our strength, to bring out that vast fund of potential energy which is in us, to the striving harmoniously for our own mental betterment and for the

protection of the public, its education, its comfort and its safety, or shall we sit quietly in a state of "inocuous desuetude"? Shall we work hard, as individuals, each doing his best, to make more perfect and more enduring and more actively alive for good our County Societies, or shall we be apathetic? It is all up to each individual one of us, for each must do his own share of the general work. No one man and no small set of men can do the work that is to be done. The strength of the American Medical Association and of the State Society, and their power for good, lie in the hands of the men who make up the County Societies. Are there not enough things for us to do to make it an object for each and every one of us to see that he leaves nothing undone that will tend to the strengthening and bettering of his County Society? The duties placed before us are plain and clear cut; will we shoulder them or ignore them? How little have we done in comparison with what we should do?

For a doctor to neglect personal attention to civic and political problems is selfish and unjustifiable. His educational advantages, his specific knowledge of sanitary requirements, his trained judgment, his self-restraint and poise in responsible situations, his familiarity with the vagaries of human nature, and the respect shown him by his fellow-citizens, make him eminently qualified for executive work, and even leadership in civic affairs. The man of education, brains and capability owes a certain part of his day to the community in which he lives, and to the associations with which his personal success and happiness are due. If he does not give it, he is not doing his full duty to mankind. The greater the advantages he possesses, the greater the call to serve his fellow-men. Few men, as a class, have a greater personal capacity than physicians. Therefore, few owe more to the State.

THE PRACTICE OF MEDICINE DEFINED BY NEW YORK STATE SUPREME COURT.

Supreme Court, Appellate Division,
First Department, December, 1906.

In the case of the People of the State of New York, *Respondent*, vs. E. Burton Allcutt, *Appellant*. No. 239, being an appeal from a judgment of the Court of Special Sessions convicting the defendant of the crime of practising medicine without being lawfully authorized and registered, in violation of the Laws of the State, Chapters 661 of 1893 and 398 of 1895. The decision was presented by Judge John Proctor Clarke, as follows:

The evidence tended to establish that in the window of the defendant's residence was exhibited a sign, "Dr. E. Burton Allcutt, Mechano-Neural Therapy"; that on the bell outside the door was the name of "Dr. Allcutt"; that in the office building on 22nd street in which the defendant had an office, there appeared upon the directory in the hall, "Dr. E. Burton Allcutt"; that he had and distributed a card reading, "Phone 3192 Riverside, Dr. E. Burton Allcutt, mechano-neural therapy, 27 East 22nd Street, room 55, Office hours 9-12 A. M. 336 West 95th Street, Office Hours, 2-6 P. M., New York City." That his receipt for services rendered was signed, "Dr. E. Burton Allcutt," that the complaining witness visited the defendant at the office address given; that defendant said that he was Dr. Allcutt, "I usually see all my patients up town in the afternoon and I am down in this office in the morning." That the witness having said that she was troubled with severe headaches, was nervous and had frequent spells of vomiting, the defendant told her he wished her to remove her corsets in order to examine her thoroughly to find out what her trouble was; he examined her chest, heart and back by placing his ear to her heart; he tapped with his fingers; that the witness said, "Doctor, I also have a very severe pain in my left arm, do you think it is rheumatism?" He said, "You are entirely too young to have rheumatism; it is from your stomach; you have malaria and stomach disease." She said to him, "Can you cure me?" The defendant said, "Certainly I can. You will have to take twelve treatments which will cost \$25 in advance"; that he said he gave no medicine at all, but quieted the nervous system. That the defendant was asked if he called at patient's residences; that he replied, "Certainly. As she resides in the Bronx I would have to charge her \$5 a visit." Witness said, "Doctor, can you cure all kinds of diseases without drugs?" He said, "Yes; I find I can cure without drugs, I can cure all diseases that any physician can cure without drugs, and also diseases that they cannot cure with drugs." He said that he had practical medicine; that he had given up drugs; that he could cure anything that physicians cured; and that she then paid \$5 for the examination and received a receipt; that subsequently the defendant called at her residence in response to a telephone call; that witness told him that she felt ill all day, that she had a chill and had been vomiting, had a pain in the region of her abdomen, that defendant took hold of her hand, felt of her pulse, looked at her tongue, examined her throat and said: "It is all from your stomach. I want you to drink a quantity of lukewarm water with salt in it." He gave it to her in spoonfuls. He said, "You must not eat pork or potatoes or any kind of sweets," and then said, "I will give you a treatment." Witness testified that defendant started to treat her back with his fingers; he said he was treating her nerves; he treated her spine by putting the fingers upon her spine, the ends of the fingers, a touching sensation, nothing like kneading; he did this for about an hour. He varied that treatment, on the neck, breast, heart and stomach in the same way, just by his fingers. He advised her, in case she had pains in the night, if the pain in her abdomen were severe, to place an ice bag on it and one on her feet, and if her bowels troubled her to place a hot water bag on her back and go to bed, not to lie on the couch, and if she got any worse to send for him. That her husband said

to him, "Doctor, what are you doing?" He replied, "I am treating her nerves. Don't you see how quiet she is now?" and that \$5 was paid for that visit. The witness testified that as a matter of fact there was nothing the matter with her, and that she was acting during these interviews as a detective.

The defendant in his own behalf testified that he practiced the art of mechano-neural therapy and that he was a graduate of the college of Mechano-Neural Therapy of Atlantic City, N. J., having received its diploma on the first of November, 1902. It was conceded that the College of Mechano-Neural Therapy was not recognized by the Regents of the State of New York and that a diploma of that institution will not give the right to practise nor to an admittance to an examination to determine the fitness of such a person to practise medicine, and that defendant was not registered as a physician in the County of New York. The defendant testified, "I started into the practice of this profession on the 11th day of November, 1902, at the present address. I have practised ever since in the City of New York and elsewhere"; that prior to his attendance at said college he had been practising massage, and was a graduate of the Mills Training School, attached to Bellevue Hospital, and had engaged in his profession as a nurse; that the statement of the complaining witness was substantially correct; that he had not studied medicine, except from the standpoint of a nurse; that mechano-neural therapy means mechanical nerve treatment, a gentle pressure on all parts of the body; that the whole theory of this science is that disease comes from the lack of blood circulation, and that the treatment proceeds upon the theory of assisting the circulation back into the normal condition.

The defendant was convicted of the crime of practising medicine without being lawfully authorized and registered.

The contention of the appellant is that, conceding all the facts proved, he was not guilty of the crime charged, inasmuch as he was not practising medicine within the meaning of the statute, in that he neither gave nor applied drugs or medicines nor used surgical instruments. Section 153 of the Public Health Law (Chap. 661 of the Laws of 1893) provides as follows: "Any person who, not being then lawfully authorized to practise medicine within this State and so registered according to law, shall practise medicine within this State without lawful registration * * * shall be guilty of a misdemeanor."

To confine the definition of the words "practise medicine" to the mere administration of drugs or the use of surgical instruments would be to eliminate the very corner-stone of successful medical practice, namely, the diagnosis. It would rule out of the profession those great physicians whose work is confined to consultation, the diagnosticians, who leave to others the details of practice. Section 146 of the Public Health Law provides that persons desiring to practise medicine must pass a Regents' examination made up of "suitable questions for thorough examinations in anatomy, physiology and hygiene, chemistry, surgery, obstetrics, pathology and *diagnosis* and therapeutics, including practice and materia medica." Diagnosis would, therefore, seem to be an integral part of both the study and practice of medicine, so recognized by the law as well as common sense. The correct determination of what the trouble is must be the first step

for the cure thereof. It is a well-known fact that the disease popularly known as consumption may, if discovered in time, be arrested, if not entirely eradicated from the system, by open air treatment in the proper climate, and that in such cases use of drugs has been practically given up. Would the physician, in such a case, who by his skill discovered the incipient disease, advised the open air treatment and refrained from administering drugs, not be practising medicine? It may be difficult by a precise definition to draw the line between where nursing ends and the practice of medicine begins, and the Court should not attempt, in construing this statute, to lay down in any case a hard and fast rule upon the subject, as the Courts have never undertaken to mark the limits of the police power of the State or to have precisely defined what constitutes fraud. What the Courts have done is to say that given legislation was or was not within the limits of the police power, or that certain actions were or were not fraudulent.

The appellant relies upon the case of *Smith vs. Lane* (24 Hun. 632), decided by the General Term, in May, 1881. That case was an action brought to recover the price which it was alleged the defendant agreed to pay the plaintiff for the treatment of himself and his wife for certain bodily disabilities. It consisted entirely of manipulation of the hands; it was performed by rubbing, kneading and pressure. The evidence given by the plaintiff was to the effect that he was employed by the defendant to perform these services for a specific consideration, and that he had performed them until the amount due to him was the sum of \$149. The referee dismissed the complaint because it appeared that the plaintiff was not a graduate of any medical school, and had no license permitting him to practise either medicine or surgery. Mr. Justice Daniels, in writing for a reversal of this judgment, said: "The act did not in terms prohibit any person from following an occupation of this description, and without some prohibition, it would seem to be as lawful as any other in which one person might render services at the request of and for the benefit of another. * * * The practice of medicine is a pursuit very generally known and understood, and so also is surgery. The former includes the application and use of medicines and drugs for the purpose of curing, mitigating or alleviating bodily disease, while the functions of the latter are limited to manual operations usually performed by surgical instruments or appliances. * * * What he did in no just sense either constituted the practice of medicine or surgery. He neither gave nor applied drugs or medicine or used surgical instruments. He was outside of the limits of both provisions, and neither one of the schools or societies mentioned in the Act had jurisdiction over him or had authority to restrain, restrict or prevent him in the occupation he was engaged in the following. While his services may have offered no benefit to the persons receiving them, he was not prohibited from performing them by anything in this Act, and no other law was violated by him which the evidence tended to show had been entered into." It will be noted that there was a private action between the parties to a contract, for services rendered, and that the public were not represented.

We do not consider the remarks of the learned Judge, above quoted as being an exhaustive or exclusive definition of the term "practice of medicine." In the same volume in which *Smith vs.*

Lane was reported appears the case of *Grattan vs. Metropolitan Life Ins. Co.* (24 Hun. 43), where the question of the admissibility of the evidence of a physician under Section 834 of the Code of Civil Procedure was under consideration. The physician did not prescribe, but took a sufficient diagnosis to enable him to prescribe. His evidence having been admitted over objection, Learned P. J., in writing for reversal, said: "The defendant insisted that there was no relation of physician and patient * * * because G. did not consult him as to a prescription and the doctor did not prescribe, *but the day has passed when it was thought that a physician's advice was of no use unless he ordered a dose of medicine.* * * * Next, the defendant insists that the doctor did not act in a professional capacity because he gave no prescription and no advice, but it is plain enough that there are cases where a physician could examine a patient, see that medicine will do no good, and that there is no advice to give him except just what the doctor gave to G., to make the best of the present because he would not remain here very long."

The appellant cites five cases in other States as in harmony with *Smith vs. Lane*, supra. *State vs. Lifring* (61 Ohio St., 39) was under the peculiar language of the statutory definition which was held to require the use of drugs in order to constitute the practice of medicine. There was subsequently an amendment of the Ohio statute, and the subsequent cases of *State vs. Gravett* (65 Ohio St., 289) and *State vs. Marble* (72 Ohio St., 21) were decided the other way. *State vs. Herring* (70 N. J. L., 34) was also decided upon the wording of the statute. *Nelson vs. State Board of Health* (57 S. W. Rep., 501), a Kentucky case, and *State vs. McKnight* (131 N. C., 717) are not entitled to be considered authorities in this jurisdiction, inasmuch as they proceed upon the proposition that in those States it would be unconstitutional for the Legislature to limit the right to practise medicine—a doctrine counter to that held in the rest of the Union. There remains but one case, that of *State vs. Mylod* (21 R. I., 631), a case of a Christian Scientist.

The Court pointed out that not only the defendant did not attempt to treat disease but he denied its very existence. In contrast with this last case is *People vs. Pierson* (176 N. Y., 201). Pierson believed in "Divine Healing." His child had catarrhal pneumonia and died. Pierson did not call in a physician, but believed the child could be cured by prayer. He was convicted under Sec. 288 of the Penal Code for wilfully omitting to furnish "medical attendance" to the child. Judge Haight concludes that the medical attendance required by the provision of the Penal Code could be furnished only by a physician duly authorized to practise under the Public Health Law, and conviction was sustained.

As opposed to the cases following *Smith vs. Lane*, the Courts of Massachusetts, Maine, Michigan, Iowa, Missouri, Colorado, Nebraska, Illinois, Ohio, Alabama, Indiana, New Mexico, South Dakota and Tennessee, refuse to restrict the "practice of medicine" to the administration of drugs or the use of surgical instruments.

In *Bragg vs. The State* (134 Ala., 164), decided on June, 1902, upon provisions of the Civil Code of that State (3261-3266), and of the Criminal Code (5333) in effect identical in language with the provisions of the statutes of this State, the Court in a most exhaustive and instructive

opinion, declared that both the man who used and the man who did not use drugs were yet engaged in the art of healing and curing human diseases; that the purpose of the medical law was to protect the public against charlatanism, ignorance and quackery, and that it was not the legislative intent to restrict the examination of those desiring to practise medicine to that class of the profession who may prescribe drugs. In that case and in the note to *O'Neill vs. State* (3 L. R. A. N. S., 762), may be found collected the cases in the several States as indicated, supra, which did not follow the definition of practice of medicine, as limited and restricted in *Smith vs. Lane*.

We are of the opinion, from the general current of the authorities throughout the country and from examination of the history and growth of our own public health statutes, that we should not apply the rule as claimed to have been laid down in *Smith vs. Lane*. When we find, as in this case, a defendant holding himself out by sign and card as a doctor, with office hours, who talks to his patients and gives treatments, who makes a diagnosis and prescribes diet and conduct and remedies, simple though they be, and who asserts the power to cure all diseases that any physician can cure without drugs and also diseases that they cannot cure with drugs, and who takes payment for a consultation wherein there was an examination and determination of the trouble, that is, a diagnosis, as well as payment for subsequent treatment, even if no drugs are administered, we must hold that he comes within the purview of the State prohibiting the practice of medicine without being lawfully authorized and registered.

The judgment of conviction should, therefore, be affirmed.

THE OSTEOPATHIC BILL.

Senate No. 146.

Referred to Committee on Miscellaneous Business

AN ACT to regulate the practice of osteopathy in the State of New Jersey, and to provide for a State Board of Osteopathic Examiners, and to license osteopathic physicians to practice in this State, and punish persons violating the provisions of this act.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. Within thirty days after the passage of this act the Governor shall appoint a State Board of Osteopathic Examiners and Registration, consisting of seven members, two to serve for one year, two to serve for two years and three to serve for three years; and at the expiration of the term of any member of such board, the Governor shall appoint a successor to serve for three years, and each member shall serve for the term for which he was appointed, or until his successor shall be appointed and shall qualify. In case a vacancy shall occur in such board by reason of the death, resignation or removal of a member before the expiration of the term for which he was appointed, the Governor shall appoint a successor to serve through such unexpired term. Every member of said board shall be a resident of the State, and an osteopathic physician in good standing, and a graduate of a legally-chartered and regularly-conducted school or college of osteopathy, but no member of said board shall be a member of the faculty of any osteopathic school or college.

Said board shall, within fifteen days after be-

ing appointed, assemble at the capitol building at Trenton, N. J., or at such other place as it may determine, and then and there organize by electing a president, secretary and treasurer from among its members, each to serve, without salary, for the term of one year, or until his successor shall be appointed and shall qualify; and upon the expiration of the term of any one of said officers, said board shall appoint a successor to serve for a like term and in like manner.

Said board shall have a common seal, and shall formulate rules to govern its actions. Its president and secretary shall have the power to administer oaths.

Said board shall meet at least twice in each year, on the second Tuesday of the months of March and July, and at such other times and such places within the State as the majority of the board shall deem necessary and convenient.

Four members of the board shall constitute a quorum for the transaction of business.

The secretary shall keep a record of its proceedings and a register of applicants for license, giving the name and location of the institution granting the applicant the degree of doctor or diplomate in osteopathy, or his certificate of attendance, the date of his diploma, and also showing whether applicant was rejected or a license granted.

The books and register of the board shall be prima facie evidence of all matters recorded therein.

Annually, before April of each year, the secretary shall furnish the Governor with a list of all licensed osteopathic physicians practicing in this State, from which list appointments shall be made, except as otherwise provided.

2. Any person engaged in the practice of osteopathy in this State prior to the passage of this act shall, within sixty days, make application to the Board of Osteopathic Examiners and Registration for a license to practice, and shall exhibit to said board a diploma issued by a legally incorporated school or college of osteopathy recognized by said board; *provided*, that such applicant shall make affidavit that he or she is the person to whom the said diploma was issued, and that he was engaged in the practice of osteopathy in this State prior to the passage of this act, and thereupon the board shall issue its license granting him the right to practice osteopathy in this State.

3. Any person desiring to commence the practice of osteopathy in the State of New Jersey, after the passage of this act, shall make a written application to the secretary of said board, on a form prescribed by the board, giving:

First. His or her name, age, which shall not be less than twenty-one (21) years, and residence.

Second. Evidence of good moral character, and that such applicant shall have, previous to his or her course in osteopathy, a certificate or diploma, issued after four years of study either in a normal, training or high school of the first grade, or in a legally constituted academy, seminary or institute of equal grade, or a student's certificate of examination for admission to the freshman class of a reputable literary college, or has received an academic education considered and accepted by the State Superintendent of Public Instruction as fully equivalent. Said applicant to appear before said Board of Examination and Registration at its first regular meeting thereafter.

Third. The applicant shall furnish evidence of

having personally attended a legally incorporated school or college of osteopathy, recognized by the board, and wherein the curriculum of study shall include instruction in the following branches, to wit: Anatomy, histology, physiology, pathology, osteopathic gynecology, bacteriology, osteopathic obstetrics, chemistry (including urinalysis), principles of surgery, hygiene and dietetics, osteopathic diagnosis (including symptomatology), physical diagnosis, clinical osteopathy, medical jurisprudence, principles and practice of osteopathy, and in such other subjects as the board may elect, and upon passing an examination in these studies satisfactory to the majority of the board shall be granted a license to practice osteopathy in this State. Said examination shall be exclusively in writing, and in English; *provided*, that holders of diplomas or certificates issued after the passage of this act shall furnish evidence of having attended not less than three full courses of at least nine months each, no two of which shall be given in any one year; and *provided further*, that upon a payment of a fee of twenty-five dollars such examination may be waived as to any person or persons who have duly graduated from and hold a diploma from any legally incorporated school or college of osteopathy, and who have duly practiced their profession in this State, or in some other State or Territory, for a period of not less than five (5) years prior to June first, one thousand nine hundred and seven, wherein the requirements were equal to the requirements in this State.

Said board may refuse to grant a license to any person guilty of unprofessional or dishonorable conduct, or any person guilty of felony, or any person addicted to the liquor or drug habit to such a degree as to render him unfit to practice, and may, after notice and hearing (at which the person shall be entitled to appear personally or by attorney and offer evidence), revoke for any such cause a license therefore granted. The words "unprofessional or dishonorable conduct" used in this section are hereby declared to mean:

a. The procuring, or aiding or abetting in procuring, criminal abortion.

b. Conviction of any offense involving moral turpitude.

4. All applications for a license shall be accompanied by a fee of twenty-five dollars, and in the event of a failure to pass, applicant may, within one year after such failure, present himself and be re-examined without the payment of an additional fee.

All osteopathic physicians qualified and practicing osteopathy in this State at the time of the passage of this act shall pay a fee of ten dollars to the Board of Osteopathic Examiners and Registration for a license to practice in this State. All fees shall be paid to the secretary of said board, but said board shall create no expense exceeding the sum received from time to time.

The expense of said board and of the examination shall be paid from the license fees above provided for, and if any surplus remains the same may be distributed among the members of said board as compensation for their services as members; otherwise they shall receive no compensation whatever.

5. The license provided for by this act shall not authorize the holder thereof to give or prescribe drugs for internal use nor to perform major surgery. Osteopathic physicians shall be subject to the same rules and regulations, both municipal and State, that govern other physicians

in the control of infectious and contagious diseases, birth and death certificates, and shall be entitled to all privileges of other physicians in matters pertaining to public health.

6. Every person holding a license from the State Board of Osteopathic Examiners and Registration shall have it recorded in the office of the clerk of the county in which he or she expects to practice, and the date of recording shall be indicated thereon. Until such license is filed for record the holder shall exercise none of the rights or privileges conferred therein.

Said clerk shall keep, in a book provided by him for the purpose, a complete list of the licenses recorded by him, with the date of the record of such license. He shall be entitled to and receive a fee of one dollar for making such record. Any person who shall practice or attempt to practice osteopathy in treating diseases, or any ailment whatsoever of the human body, or who shall use any of the terms or letters "Osteopathy," "Osteopathist," "Doctor of Osteopathy," "Diplomate in Osteopathy," "D. O.," "Osteopathy," or any other titles or letters under such circumstances as to induce the belief that the person who uses such terms is engaged in the practice of osteopathy, without having complied with the provisions of this act, shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be punished for the first offense by a fine of not less than one hundred dollars (\$100), or by imprisonment in the county jail for a period of not less than thirty (30) days, or by both fine and imprisonment; and for each subsequent offense the punishment shall be double that of the preceding one; and it shall be the duty of the respective district attorneys of the counties of this State to prosecute violations of the provisions of this act.

Provided, however, that nothing in this act shall be construed as prohibiting, infringing upon, or in any manner interfering with any other school, art, system or science of healing in this State from the practice of their profession as provided for by the laws of the State of New Jersey.

7. All acts and parts of acts conflicting with the provisions of this act are hereby repealed.

8. This act shall take effect immediately.

Correspondence.

STATE EXAMINATION OF MIDWIVES.

Camden, N. J., February 28, 1907.

Dr. D. C. English, Editor:

Attention is being given by the medical journals to the examination and licensing of midwives by the State, in the interest of the public and of vital statistics, relating to child birth. This attitude is warranted, especially since the publication of an article by Miss F. E. Crowell, assistant secretary of the New York Public Health League, in *Charities and the Commons*, in which she states, among other things, that of 500 midwives visited in the State of New York "less than ten per cent. could be considered capable, reliable women." A synopsis of this report was published in *The Journal*, A. M. A., for February 23, 1907.

A large percentage of the foreign population, especially in the cities, employ midwives in parturient cases; partly because of economic conditions and the belief that labor is a normal, physiological condition, and partly because of the views held by many of the laity that midwives, who

have born children, know more about the art of obstetrics than physicians. While the processes of pregnancy, parturition and the puerperium are normal and physiological, in the majority of cases they may quickly pass into an abnormal and pathological state requiring the exercise of the highest skill to obtain a successful issue. For these reasons the practice of midwifery is brought to the attention of the profession.

The practice of midwifery, however, by women is as old as the human race. Sacred history speaks in plaintive tones of the suffering and death of Rachel, "beautiful and well-favored," and of the admonitions of her attending midwife, "Fear not, thou shalt have this son also," and of Pharaoh's cruel order to the Hebrew midwives: "When ye do the office of a midwife to the Hebrew women and see them upon the stools; if it be a son, then ye shall kill him; but if it be a daughter, then shall she live." The Greeks and Romans invoked the aid of the goddesses that presided over child birth, and the practice of midwifery, based upon superstition and empiricism and performed with incantations, was wholly in the hands of women.

In Europe the practice was confined to women for several centuries, and attendance upon parturient cases by men was looked upon as a crime, except when difficult or delayed labor called for Caesarean section, or other surgical treatment. The invention of the obstetric forceps by Peter Chamberlin of England in the early part of the seventeenth century ushered in a new era in obstetric art. This invention marked the decline of the midwife and the advent of the accoucheur. Following this invention, the discovery of anaesthetics and the application of the principles of asepsis have placed the practice of obstetrics on an enduring basis and reduced the mortality to practically zero. The midwife and the monthly nurse still ply their vocation. Shakespeare has delineated in the "Nurse of Juliet," the vulgarity and loquacity of the nurse of his era, and Dickens has illustrated in the intemperance and ignorance of "Sairey Gamp" the monthly nurse of more recent times. These characters are rarely found at the present time. The educated midwife and the trained nurse now occupy the field.

Early in the last century midwifery schools were established in the principal cities of Europe to correct existing evils, and recent graduates of many of those schools are coming to this country, in large numbers to ply their avocation. Within recent years midwifery schools have been established in New York, Chicago and other cities (New York City now having four schools), and the graduates of those schools are now applying, in increasing numbers, for the license of this and other States. The practice of the midwife appears to be increasing among foreign residents. The incomplete education and training of a large percentage of these applicants in the science and art of obstetrics and in the principles of asepsis and antisepsis have been demonstrated in the midwifery examinations of this State. It is important, therefore, that other States should follow in the footsteps of New Jersey and regulate the practice by mandatory enactment.

The State Board of Medical Examiners of New Jersey early recognized the dangers of unregulated midwifery practice; placed the matter before the Legislature and secured the passage of an "Act to Regulate the Practice of Midwifery in the State of New Jersey," which was approved March 28, 1892. This act is among the earliest

of its kind in the country, if not the first, and was effected largely through the efforts of Dr. William Perry Watson, then Secretary of the State Medical Board. The justice and necessity of this act have been demonstrated. The effort of New Jersey in this pioneer work should not be overlooked by THE JOURNAL.

New Jersey requires that applicants for its midwifery certificates shall submit certified evidence as to name, residence, nativity, period of study and practice, showing also attendance of at least one school year, including eight months of lectures, and graduation from a legally incorporated school of midwifery before they can be admitted to the examination. If graduates from a foreign school, their credentials must bear the seal of the consul of the country in which it was issued. Examination is required in (1) anatomy of the female pelvis and pelvic organs, (2) menstruation, (3) pregnancy, (4) mechanism of a normal labor, (5) management of a normal labor, (6) sepsis and antisepsis in relation to labor, (7) hygiene of the mother and infant, (8) special care of the lying-in-room and (9) abnormal labor requiring the attendance of a physician. The credentials of all applicants, whether licensed or rejected, are filed in the State Library. To those who pass the examination, a State certificate of license is issued with a certified copy which must be filed in the office of the clerk of the county in which the applicant intends to practise. All State midwifery licenses are issued conditionally to those who pass the examination and may be revoked for cause. The conditions include county registration, the reporting of cases of child birth to the proper authorities, cleanliness while attending a case of labor, when to call a physician, the administration of drugs, etc. The conditions are set forth in detail in the annual report of the examining board to the Governor and copies are given to each licensee with the certificate of license by the State.

While the statement of Miss Crowell that of 500 midwives visited by her "less than ten per cent. could be considered capable, reliable women," may apply to the State of New York, this criticism does not apply to the midwifery licentiates of the State of New Jersey.

E. L. B. GODFREY, M. D.

Reports from County Societies.

ATLANTIC COUNTY.

A. Burton Shimer, M. D., Reporter.

The past month has been a busy one in medical circles in Atlantic County. On February 26th a special meeting of the Society was held at the Hotel Windsor to hear Dr. J. N. McCormack. This meeting was very well attended. President E. C. Chew announced the committees on Legislation and Public Health and Outing, also delegates to other County Societies.

Dr. J. N. McCormack of Kentucky, the representative of the A. M. A., was then introduced and made a masterly plea for harmony and mutual coöperation in instituting a useful course of post graduate instruction in our County Society. At 6.30 the speaker's remarks were interrupted by adjournment to dinner, after which he again took up the subject. A motion was adopted that the President appoint a committee of three to take up the work and recommend a plan to the Society to carry into effect Dr. McCormack's suggestions.

A rising vote of thanks was given Dr. McCormack for his eloquent and inspiring discourse.

In the evening Dr. McCormack spoke to a large audience, both professional men and laymen, in the auditorium of the High School on subjects of timely interest. This meeting was under the auspices of the Atlantic County Medical Society and in charge of a committee of the officers of the Society, viz: E. C. Chew, President; C. M. Fish, Vice-President; Wm. F. Ridgway, Secretary and Treasurer; E. A. Reiley and J. A. Joy, Censors.

The chair appointed the following committee to take up the work of a post-graduate course as outlined by Dr. McCormack, viz: C. M. Fish, W. E. Darnall, W. Reynolds.

On March 8th the regular quarterly meeting of the Atlantic County Medical Society was held in the Carnegie Public Library building, the use of which was donated by the trustees.

The chief business before the meeting was the report of a special committee of Drs. Fish, Reynolds and Joy on Dr. McCormack's recommendations in regard to post-graduate work. The adoption of the plan was recommended; first by two meetings monthly on the first and third Fridays of April, May and June, when subjects would be discussed in a preliminary course. July and August no meetings. September to take up the A. M. A. plan to be submitted later. The same committee was continued in charge and has arranged a program covering the first six meetings.

Dr. Darnall, on behalf of the trustees, offered the use of the room in the Carnegie Public Library building for use of the Society for the course. Reading of the clippings in the scrapbook by the Secretary took place and explanations by the members of their names appearing in the public print followed. Dr. W. Reynolds presented a paper on "Therapeutic Notes on the Use of Adrenalin Ointment in Neuralgia," with an interesting list of cases in which it had been used successfully.

Atlantic City, March 16, 1907.

MERCER COUNTY.

Charles H. Mitchell, M. D., Reporter.

On Tuesday, March 12th, the Mercer County Component Medical Society held their regular monthly meeting at Trenton. Dr. Charles F. Adams gave a very interesting and instructive address on "Symptoms of Diseases of the Sinuses," during which he displayed and demonstrated the use of various instruments in this branch of nasal and eye work. I will forward an abstract of his address later. Dr. George Moore delivered a most interesting description of a case of tubercular pyopneumothorax that recently came under his observation.

On February 14th Dr. J. N. McCormack of Kentucky gave an excellent address before the local Medical Society, and in compliance with his suggestions a committee was appointed to prepare subjects for a post-graduate course. The entire Society seems to favor such a movement. We were unable to secure an evening public meeting for Dr. McCormack, due to the fact that on that evening several important popular events were scheduled to take place.

To Reduce Obesity.—Von Basch advised graduated exercises and walking, short of exhaustion; restriction of carbohydrates and liquors; mineral waters containing Glauber salts; and carbonated brine and vapor baths.—*Denver Medical Times.*

Intestinal Antisepsis in Fevers.—William F. Waugh declares that in every febrile disease, specific or otherwise, there is necessarily intestinal decomposition, toxin formation and absorption, and toxemia. He believes that about one-third of the fever and other symptoms may be credited to this cause, since the illness decreases in about this proportion after the bowels have been cleaned out and disinfected. The various symptoms are relieved to a much greater degree. These considerations apply to all fevers equally. When the deadly infectious nature of a typhoid stool is taken into account, it cannot be considered as a fit dressing for an ulcer. Cleanliness and asepsis are as desirable here as elsewhere. The writer expresses his preference in the choice of antiseptics for the use of the sulphocarbolates, following a complete emptying of the alimentary canal by doses of calomel, salines, and colonic flushings. These drugs are perfectly safe and never cause hemolysis or hematuria. They are efficient and inexpensive. There is little taste when they are taken in hot water solution. When chemically pure, they are far more apt to settle an irritated stomach than to cause irritation. Toxic effects are not to be apprehended from overdosage.—*The American Journal of Clinical Medicine.*

Obituary.

Bartow—In Three Bridges, Hunterdon County, N. J., March 27th, Dr. George Warren Bartow, aged sixty-three years.

He had practiced medicine at Three Bridges for thirty-four years. He was a member of Company A, Fifteenth Regiment, New Jersey Volunteers, and was wounded at the battle of Petersburg. At the close of the war he entered the College of Physicians and Surgeons in New York, from which he was graduated in 1873. He became a member of the Hunterdon County Medical Society in 1873 and took an active part in the work of the Society. He leaves a wife and a son.

Book Review.

DISEASES OF THE LUNGS.

By Robert H. Babcock, A. M., M. D., Author of "Diseases of the Heart and Arterial System"; formerly professor of clinical medicine and diseases of the chest, Illinois State University; consulting physician to Cook County Hospital, etc., etc.
With 12 colored plates and 104 text illustrations;
809 pages; cloth; \$6 net.

D. Appleton & Co., New York, 1907.

The author in the preface to this volume, speaking very modestly of his work, expresses his appreciation concerning the criticism that may be passed upon the chapters devoted to pneumonia and pulmonary tuberculosis. After spending more time than usual in examining this volume, we have no hesitation in commending it, especially the chapters referred to—on pneumonia and tuberculosis. These diseases are very ably discussed from all points of view in a clear, concise and practical way, special consideration being given to their aetiology, diagnosis and treatment. The author has given as a volume on the diseases of the bronchi, lungs and pleura which, we believe will prove instructive and helpful to every student and practitioner who possesses and intelligently uses it.

THE JOURNAL

OF THE

Medical Society of New Jersey

APRIL, 1907.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any one failing to get the paper promptly will confer a favor upon the Publication Committee by notifying them of the fact.

All communications relating to the JOURNAL should be addressed to the Committee on Publication, 95 Essex Avenue, Orange, N. J.

HIGHLY IMPORTANT.

We have hurried the preparation and printing of this issue of THE JOURNAL in order to call the attention of the members of our Society to the necessity for prompt and vigorous action to defeat the Osteopathic Bill—Senate No. 146, now pending in our Legislature. We urge every member: (1) to read carefully that bill, Dr. Halsey's paper, the decision of the New York Supreme Court on what constitutes the practice of medicine, and the editorial on lowering the standard of medical licensure, all of which will be found in this issue of THE JOURNAL; and (2) to see or write to their respective Senators and Assemblymen and show them that the welfare of the public—in the prevention of disease and the saving of human life—*requires the defeat of that bill*. We do not believe these masseurs or osteopaths should be recognized as physicians and be granted a separate board of examiners; but if our legislators insist upon its passage, let us enter our protest and let it be known that, in this controversy, we are standing for the saving of human life in thus maintaining the great principle—that THE EDUCATIONAL QUALIFICATIONS AND GOOD MORAL CHARACTER ARE THE TRUE AND DECISIVE BASES ON WHICH LICENSURE TO PRACTICE MEDICINE AND SURGERY SHOULD BE GRANTED. The utmost that should be granted the osteopaths would be one member on our present State Board of Medical Examiners.

SHALL THE STANDARD OF MEDICAL LICENSURE BE LOWERED?

In another column of this issue of THE JOURNAL will be found the Act introduced into the Senate February 25, 1907, known as Senate Bill No. 146, "To regulate the practice of Osteopathy in the State of New Jersey, and to provide for a State Board of Osteopathic Examiners, and to license osteopathic physicians to practice in this State, and punish persons violating the provisions of this Act."

It will be seen by a careful reading of this bill that it is far more objectionable than the bill introduced into the Assembly last year and killed in committee through the excellent work of our Committee on Legislation and the intelligent scrutiny and conscientious desire of the members of the Assembly committee which had the bill in charge to maintain the high standard of medical education and thereby safeguard the health and lives of our citizens.

If the most objectionable part of this Senate bill—Section 5, which confers on osteopaths all the rights and privileges and frees them from the responsibilities of regular scientific practitioners of medicine, except the prescribing of drugs *internally* and of performing *major* surgical operations—were stricken out this bill ought to be defeated because of other serious defects. It is far less strict, and exceedingly faulty in its provisions constituting its board of examiners, prescribing its duties and governing its granting of licenses than the law constituting and governing our present efficient board of medical examiners. We note a few defects. 1. It does not provide for the qualification of any osteopathic appointees at any time, but only that their successors shall qualify; they are not required after appointment to take, subscribe and file in the office of the Secretary of State the oath or affirmation required by the present law; (2) they are left to "formulate rules to govern its actions"; it does not definitely provide for the manner of conducting examinations—requiring that the applicant shall

be known only by number to the examiners, that the written vote of each examiner on the examination papers of each candidate shall be given and that their papers shall be filed in the State Library for public reference, nor does it require that the board shall keep an *official register* of all applicants for a license to practice medicine and surgery in this State giving the important information concerning the applicant's preliminary and medical education and whether he was examined, licensed or rejected. The osteopathic bill only provides—Section 1, that the secretary shall keep a register of applicants for license, giving the name and location of the institution which granted the applicant the degree of doctor or "diploma" in osteopathy, or his certificate of attendance, the date of his diploma and also whether the applicant was rejected or a license granted; (3) Section 2 of this bill would permit any osteopath who has been practicing in this State prior to its passage, to obtain license from the board of osteopathic examiners within 60 days after its passage, simply on exhibiting a diploma issued by a legally incorporated school or college of osteopathy recognized by said board. This would give legal standing to all the quacks, pretenders and charlatans who could exhibit a diploma from any private unincorporated school of osteopathy in any State. Why should not these men or women be required to pass an examination before receiving license? (4) Section 3 permits the board to license osteopathic physicians of this or any other State, at any time to practice without examination upon the payment of their fee; no examination in any State is specified. *In every State a State medical examination of a definite scope is the basis for reciprocity in medical licensure.* (5) The State now demands 36 months of medical study as a prerequisite for admission to the examination, the osteopathic bill requires only 27 months. We will not now consider comparatively the standing of the respective colleges (of regular scientific medicine and of osteopathy)—

the scientific character of the text-books or thoroughness of the instruction.

As we have intimated, Section 5 is by far the most objectionable feature of this osteopathic bill. It clothes these osteopaths with all the privileges and powers of the licentiates of the present Board of Medical Examiners who have passed rigid examinations without requiring of the osteopathic licentiate any examination as to his educational qualifications and frees him from the responsibilities which attach to the licentiate of the present board of examiners. It permits the osteopath to use drugs *externally* and to perform all but major surgical operations; to treat contagious and infectious diseases and to give birth and death certificates. We cannot here enlarge upon the serious consequences of this section of the bill if it shall be passed. They are apparent to every intelligent physician and they should be brought to the attention of every member of our Legislature who may be called upon to vote on this bill. We urge upon every member of our State Society to explain this feature of the bill especially to the Senator and Assemblymen who represent his district, that they may vote intelligently on this bill. Nor will we here discuss another question which should need but little argument with intelligent men who have the health interests of our State as the great principal which actuates them in deciding this matter. **WHY SHOULD WE HAVE TWO EXAMINING BOARDS FOR THE EXAMINATION AND LICENSING OF MEDICAL MEN IN THIS STATE?** The present Board of Examiners licenses not only the old school or regular medical men but also those of the homeopathic and eclectic schools. If the masseurs or osteopaths claim to be physicians and as such need license to practice why should they have a special board and be granted special privileges and powers, and why should they be relieved of any of the responsibilities? Why do they not apply for a representative on the present Board of Medical Examiners?

That the passage of this osteopathic bill

would prove disastrous in lowering the high standard of medical education now exacted by the State in the interest of the public health and the consequent increase of infectious and contagious diseases and the mortality from these and other diseases, we believe is beyond question. The physicians of our State, as men trained in medical matters, are best qualified to judge and advise. Let us do our full duty in setting this matter clearly before our legislators. Then if this bill is passed and disease and mortality are thereby increased the responsibility is removed from us to the legislators whose votes shall have contributed to the increase of disease and deaths.

A similar law has recently failed to pass two State Legislatures, and we are assured it will fail in the New York State Legislature.

We ask every member of our State Society to carefully read Dr. Halsey's paper on "The Medical Man in Politics for the Public Good," and to act on his suggestion. It is high time for action on the part of the three or four thousand medical men of New Jersey.

THE MEDICAL MAN IN POLITICS.

We publish with much pleasure in this issue of THE JOURNAL Dr. L. M. Halsey's paper on "The Medical Man in Politics for the Public Good" and bespeak for it the careful reading of every member of our Society, and after that their intelligent action. It is forceful and timely. If we are to succeed fully in securing and maintaining the educational qualification as the essential requirement for medical licensure; if we are to have laws enacted that will adequately meet the needs for the protection of our citizens against contagious and infectious diseases and quackery; if we are to succeed in guarding the children and youth of our State against diseases that arise not only from contagion and infection but also from bad ventilation, eye-strain, faulty educational methods, etc., we as the only profession or body of men which is qualified to judge in health matters affecting the indi-

vidual and the community and therefore has a right to judge, and whose judgment should therefore be heard and respected, must get together and unitedly express our judgment and insist upon laws and measures that will tend to conserve health, prevent epidemics, reduce to the minimum if not wipe out entirely diseases that are preventable, overthrow the nostrum evil and prevent incompetent and unscrupulous men and women from treating disease by any method whatsoever.

PRIZE ESSAY.

This prize was instituted by the Medical Society of New Jersey at the annual meeting in 1905, and is open for competition to the members of the Component (County) Medical Societies.

The subject chosen is "The Symptoms, Etiology, Pathology and Treatment of Pneumonia."

The essays must be signed with an assumed name and have a motto, both of which shall be enclosed in a sealed envelope containing the author's name, residence and component society.

The essay shall contain not more than 4,000 words, and must be characterized by originality in investigation and thought, and by clearness and conciseness of expression, and be, in the judgment of the committee, of decided value to the members of this society, and to the profession generally. Failing in these respects, no award will be made.

The essays, which should be type-written, with the sealed envelope, must be placed in the hands of the committee on or before the first day of May, 1907.

The committee will select the first two essays in order of merit. To the first will be awarded the prize of one hundred dollars, to the second that of honorary mention.

The unsuccessful authors will receive back their essays upon their identification the chairman of the committee. The successful essay will be the property of the society and be published in its transactions..

CHARLES J. KIPP, Newark, *Chairman*.

WALTER B. JOHNSON, Paterson.

DAVID C. ENGLISH, New Brunswick.

It will be a cause of deep regret, especially to the members of the Prize Essay Committee, if we fail to have at least one essay presented at the coming annual meeting of our State Society. The subject—Pneumonia—is one of the greatest importance, for there is no disease that more needs the study, not only of our brainiest young men but also of our specialists practicing in this branch of medical science. It is not creditable to the medical profession to acknowledge, in these days of great advance in the sciences and art of our profession, that we do not more fully understand this disease and are not yet able to cope as successfully as we should with its prevention and cure. We recognize the fact that it is a preventible disease, and in view of the fact that it causes about 3000 deaths per annum in our State (in 1904 the number was 3486 or 9.88 per cent. of total deaths from all causes), we should strive to solve the problems concerning it that have thus far baffled attempts at solution.

Since writing the above we have received Dr. Babcock's volume on "Diseases of the Lungs," referred to in another column, which contains a valuable contribution to our knowledge of this disease and its management, and which we hope will stimulate further study and lead to our early mastery of this disease.

OUR NEXT ANNUAL MEETING.

We call the attention of our readers, at this early date, to the fact that the next annual meeting of the Medical Society of New Jersey will be held June 25-27th at Cape May, in the Hotel Cape May, in order that they may make their arrangements to attend. This will probably be one of the best meetings the Society has ever held. The members of the Committee of Arrangements are determined to do everything possible to contribute toward that end. The hotel has just been built and its furnishing on a most elaborate and elegant scale is nearing completion. Its manager urged our Society to hold its meeting in that hotel, making extraordinary rates and prom-

ises for the satisfaction and comfort of our members. The Committee on Scientific Work with the Committee on Program have already secured the promise of papers and discussions that will command the attention and prove profitable to those who attend. We expect to give in the next issue of THE JOURNAL a preliminary program, but we will here state that the committee has been fortunate in securing such eminent men as Dr. Albert Vander Veer, of Albany, N. Y., and Dr. Morris Manges, of New York city, to deliver the orations on Surgery and Medicine respectively.

Let every member of our Society who can do so make his or her plans for the coming summer to take in this annual meeting. Dr. Norton L. Wilson, Chairman of the Committee on Scientific Work, requests early reports from the County Society Reporters.

MEDICAL EXAMINERS' FEES.

We herewith publish a list of the life insurance companies paying a \$5 flat fee, as far as known to us. If our readers know of others they will please inform us:

Aetna Life, Hartford, Conn.
 American National Insurance Co., Galveston, Texas.
 Citizens Life, Louisville, Ky.
 Capital Life, Denver, Col.
 Fort Worth Life, Fort Worth, Texas.
 Manhattan Life, New York City.
 Massachusetts Mutual Life, Springfield, Mass.
 Mutual Benefit Life, Newark, N. J.
 National Life, Montpelier, Vt.
 Northwestern Mutual, Milwaukee, Wis.
 Pacific Mutual Life, San Francisco, Cal.
 Provident Life and Trust, Philadelphia.
 Reliance Life, Pittsburg, Pa.

We believe that these companies are thoroughly reliable, that they do not pay their officers excessive salaries, and are not mixed up with trusts and political parties. They should be favored in every way possible by members of the medical profession.

Dr. Randall, Medical Director of the American National, in a letter stating that the company has adopted the \$5 fee, says: *"It is the desire of this company to employ only the best examiners, and they realize they can only get good men by paying a reasonable fee."*

That is good common sense and shows that this company is run on sound business principles.

Clinical Department.

Gall Stones; Distended Gall Bladder; Obstruction of Cystic Duct; Cholecystectomy; Recovery.

By Frank M. Donohue, M. D.,
New Brunswick, N. J.

A rather unusual case occurred in my practice a short time ago and I write to present a brief report of the same.

Mrs. S., age 52, resident of Hopewell, N. J. I saw the patient in consultation with her physician, Dr. George Van Neste. She gave the following history: She began to complain of a lump in her right side between the free border of the ribs and the anterior spine of the ileum. This was examined by a competent surgeon who made a diagnosis of floating kidney. Two or three times subsequently he examined the tumor and said, "as it is not any larger I would advise letting it alone." Six weeks prior to my visit she slipped and fell, striking on a pole across the abdomen, was taken to her home, vomited some, had a little temperature and some disturbance of pulse rate. The vomiting subsided, the pulse came down to normal, but still her temperature ranged from 100 to 101½. On examination a tumor could be seen and felt in about the kidney region, it was fluctuating, not very tender to the touch, there was tympanitis between the liver and the tumor, flat over the tumor, tympanitic below and slight dullness behind, the urinary examination was negative. I told the doctor that I could not make a complete diagnosis but advised an operation, because evidently the tumor was growing and I thought it would cause death before very long. She came to the John Wells' Memorial Hospital, New Brunswick, where I operated on her the next day. I made a long incision through the right linea semilunaris and on opening the abdomen I first examined the kidney, which was found healthy. The tumor was situated in the lumbar region and was covered by omentum which was firmly adherent to it. In separating the omental adhesions I came upon a small body which felt hard and as I removed it I found that it was a gall stone. The omentum was finally separated and in doing so I found nineteen gall stones *outside* the gall bladder and between it and the omentum. The gall bladder was as large as a good sized cocoanut. This was incised, the contents were bile-stained pus and fifty-three gall stones: one very large one

in the cystic duct which was milked out back into the gall bladder and removed. The cystic duct was tied off and the whole gall bladder removed. A drainage tube, surrounded by gauze was inserted and the wound stitched up. She is now convalescent.

[We shall be pleased to receive from any of our members reports of such interesting cases, for this department of our JOURNAL.—EDITOR.]

PROPRIETARY PREPARATIONS APPROVED BY THE A. M. A. COUNCIL ON PHARMACY AND CHEMISTRY.

(Continued.)

ANTITHYROIDIN, MÆBIUS.

The blood-serum of sheep from which the thyroid gland has been removed at least six weeks before the blood is drawn, preserved by the addition of 0.5 per cent. of phenol.

Actions and Uses.—For actions and uses see Antithyroid Preparations. Dosage.—It is administered by the mouth in doses beginning with 0.5 to 1 Cc. (8 to 15 min.) three times a day, gradually increasing the dose as necessary. Manufactured by E. Merck, Darmstadt. (Merck & Co., New York).

ARGENTAMIN.

An aqueous solution of silver nitrate and ethylenediamine, corresponding to 10 per cent. of silver nitrate.

Actions and Uses.—It is antiseptic and astringent like other silver salts, with the asserted advantage of being non-irritant and more penetrating than silver nitrate. It is said to be useful in all cases where the non-caustic action of silver nitrate is indicated. Dosage.—It may be used in the anterior urethra in 0.25 to 1 per cent. solution; in the posterior urethra in from 1 to 4 per cent. solution; in ophthalmology in 5 per cent. solution. Manufactured by Chemische Fabrik auf Actien, vorm. E. Schering, Berlin. (Schering & Glatz, New York.)

ARGONIN.

A soluble casein compound containing 4.28 per cent. of silver.

Actions and Uses.—Its action and uses are similar to those of silver nitrate, but it is claimed to have greater power of permeating living colloid membranes than other silver albumoses. It is applied as an injection in 0.1 to 0.2 per cent. solution; in ophthalmic practice a 10 to 20 per cent. solution in glycerin may be used. Dosage.—It is generally used in 0.5 per cent. solution, but even 20 per cent. solutions have been injected without producing irritant symptoms. Manufactured by Farbwerke vorm. Meister, Lucius & Bruening, Höchst a. M. (Victor Koechl & Co., New York.)

ARGYROL.

A compound of a derived proteid and silver oxide, containing from 20 to 25 per cent. of silver.

Actions and Uses.—Solutions of argyrol (20 to 50 per cent.) are said to be non-irritating to mucous membranes. Taken internally it is said to be non-toxic. It is claimed to be an antiseptic. It is recommended in urethritis and cystitis, in conjunctivitis and in affections of the nose, throat and ear. Dosage.—It is employed in from 10 to 25 per cent. and even stronger solutions. Manufactured by Barnes & Hille, Philadelphia.

ARISTOCHIN.

Aristochin. — $\text{CO} (\text{C}_{20}\text{H}_{23}\text{N}_2\text{O}_2)_2 = \text{C}_{41}\text{H}_{46}\text{N}_4\text{O}_5$, the neutral carbonic ester of quinine.

Actions and Uses.—The same as those of quinine, but, since it is only slowly acted on by acids, it is said not to produce disturbance of the stomach and to be notably free from tendency to production of cinchonism. Dosage.—The same as that of quinine, in powder, mixed with milk sugar, dry on the tongue or suspended in liquids. Manufactured by Farbenfabriken, vorm. Friedr. Bayer & Co., Elberfeld, Germany. (Continental Color & Chemical Co., New York.)

ARISTOL.

A name applied to Thymolis Iodidum, U. S. P. Manufactured by Farbenfabriken vorm. Friedr. Bayer & Co., Elberfeld, Germany. (Continental Color & Chemical Co., New York.)

ASPIRIN.

Aspirin, $\text{C}_6\text{H}_4\text{O}(\text{CH}_3\text{CO})_2\text{COOH}$, 1:2= $\text{C}_9\text{H}_8\text{O}_4$, the acetyl derivative of salicylic acid.

Actions and Uses.—It acts like salicylic acid, over which it possesses the advantage of producing less of the undesired local and systemic side effects, on account of the slow liberation of the salicylic acid. It passes the stomach unchanged, the decomposition beginning in the intestine. Dosage.—0.3 to 1 gm. (5 to 15 grains) in capsules or wafers, or dissolved in sweetened water or dry on the tongue, followed by a swallow of water. The powder should be dispensed in waxed paper. Manufactured by Farbenfabriken, vorm. Friedr. Bayer & Co., Elberfeld, Germany. (Continental Color & Chemical Co., New York.)

BENZOSOL.

Benzosol, $\text{C}_6\text{H}_4(\text{OCH}_3)(\text{C}_6\text{H}_5\text{COO}) = \text{C}_{14}\text{H}_{12}\text{O}_3$, a crystalline compound of guaiacol in which the hydrogen of the hydroxyl is replaced by benzoyl.

Actions and Uses.—Benzosol is decomposed slowly in the intestinal tract into guaiacol and benzoic acid which exert their proper actions. The liberated constituents are absorbed and excreted in the urine. It is not irritating. Its uses are analogous to those of creosote and of benzoic acid. It is recommended in incipient pulmonary tuberculosis, as an intestinal antiseptic in fermentation, diarrhea, typhoid fever, diabetes mellitus and as a urinary disinfectant in cystitis, etc. Dosage.—0.2 to 0.6 Gm. (3 to 10 grains), in powder, capsule, pill, or suspended in liquids or as an emulsion. Manufactured by Fabwerke, vorm. Meister, Lucius & Bruening, Hoechst a. M. (Victor Koechl & Co., New York.)

BETA-EUCAINE HYDROCHLORIDE.

Beta-eucaine hydrochloride, $\text{C}_5\text{H}_7\text{N}(\text{CH}_3)_3(\text{C}_6\text{H}_5\text{COO})\text{HCl}$, the hydrochloride of 2,6,6-trimethyl-4-benzoyl-hydroxypiperidine. Actions and Uses.—Beta-eucaine hydrochloride is a local anesthetic like cocaine, but weaker and devoid of the stimulating properties of the latter. It does not dilate the pupil, nor does it contract the blood vessels as does cocaine. It has the advantage of stability even on prolonged boiling. It may be used in all cases in which cocaine is indicated as a local anesthetic, especially in ophthalmology. Dosage.—It may be applied in a 2 to 3 per cent. solution to the eye, 5 to 10 per cent. for nose and throat, and 5 to 10 per cent. for ointment for hemorrhoids. Manufactured by Chemische Fabrik auf Actien, vorm. E. Schering, Berlin. (Schering and Glatz, New York.)

BETA-NAPHTHOL BENZOATE.

Beta-naphthol benzoate, $\text{C}_{17}\text{H}_{12}\text{O}_2$, the benzoic ester of B-naphthol.

Actions and Uses.—Beta-naphthol benzoate is split up into its constituents on reaching the intestinal tract and acts as an antiseptic. It is said to be diuretic. It is used internally as an intestinal antiseptic in diarrhea and typhoid fever. Externally it has been recommended as a parasiticide in the form of 3 to 10 per cent. ointment, and has been used in psoriasis, eczema, scabies, etc. Dosage.—0.2 to 0.5 Gm. (3 to 8 grains); maximum dose, single, 1 Gm. (15 grains), daily 4 Gm. (60 grains). Manufactured by Fabrik von Heyden, Radebuel near Dresden. (Merck & Co., New York.)

BETOL.

Betol, $\text{C}_6\text{H}_4\text{OH.COO}(\text{C}_{10}\text{H}_7) = \text{C}_{17}\text{H}_{12}\text{O}_3$, the salicylic ester of B-naphthol.

Actions and Uses.—Betol is not affected in the stomach, but is split up in its original components when it reaches the intestinal tract by the pancreatic juice and intestinal secretions. It is believed to act as an intestinal antiseptic and, being excreted in the urine, to act in a similar way in the bladder. It has the anti-rheumatic properties of salicylic acid. It is recommended for intestinal fermentations, catarrh of the bladder, particularly in gonorrheal cystitis, for rheumatism, etc. Dosage.—0.3 to 0.5 Gm. (4 to 8 grains) in cachets, milk or emulsion. Manufactured by the Heyden Chemical Works, New York.

BISMAL.

Bismal, $4(\text{C}_{15}\text{H}_{12}\text{O}_{10}).3\text{Bi}(\text{OH})_3 = \text{Bi}_3\text{C}_{45}\text{H}_{36}\text{O}_{30}$, a compound of bismuth hydroxide and methylenedigallic acid.

Actions and Uses.—Bismal is an astringent and is recommended for the treatment of chronic diarrhea. Dosage.—0.12 to 0.3 Gm. (2 to 5 grains) in cachets or powder. Manufactured by E. Merck, Darmstadt. (Merck & Co., New York.)

BOROCHLORETONE.

A mixture of 1 part chloretone with 3 parts boric acid.

Actions and Uses.—An antiseptic and anesthetic, used externally as a surgical dressing powder. Prepared by Parke, Davis & Co., Detroit, Mich.

BROMETONE.

Brometone, 1,1,1-tribrom-2-methyl-propan-2-ol, $\text{CBBr}_3\text{C}(\text{OH})(\text{CH}_3)_2 = \text{C}_3\text{H}_7\text{OBr}_3$, produced by the reaction of acetone on bromoform.

Actions and Uses.—Brometone is claimed to have the sedative action of the bromides without the disadvantage of producing bromism. In doses of 0.3 Gm. (5 grains) four or five times a day, in adults, it is claimed to cause no unpleasant results and to produce no disturbance of the digestive organs, and to have no appreciable effect on the secretions. Its action is prompt and its effect is manifest for several hours. In doses exceeding 1.6 Gm. (25 grains) daily it may produce dizziness, vertigo, anorexia, and mental hebetude, all of which symptoms disappear on discontinuance of its use. Therapeutically it has been recommended in mild conditions of excitation and insomnia, in so-called narcotic abstinence, in hysteria and in nervous affections generally. It relieves some forms of cough and is said to produce amelioration in about 60 per cent. of cases of epilepsy. It has been used to relieve dizziness due to labyrinthine disturbances. Dosage.—The dose is 0.3 Gm. (5 grains), to be repeated two or three times during twenty-four hours. Manufactured by Parke, Davis & Co., Detroit.

(To be continued.)

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THE CHRONIC GASTRO-INTESTINAL DISEASES OF INFANTS WITH A DISCUSSION OF THEIR RELATION TO THE SUMMER MORTALITY.*

By Francis H. Glazebrook, M. D.,
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*Visiting Physician to the Speedwell Country
Homes Society, of New York City.*

It would be impossible to cover the conditions suggested by the title of my paper separately in an article of this kind. I shall endeavor, therefore, to review hurriedly and collectively the common forms of Chronic Gastro-Intestinal disorders of infants, discussing especially what I consider the most important part of this subject from the standpoint of the general practitioner, namely, the cause and prevention of these conditions, and their relation to the summer mortality.

The Gastro-Intestinal disturbances of infants may be divided into those due to improper food: (1) the mechanical irritative diarrhœas, and those due to infections (2) the infectious diarrhœas. The latter class being subdivided into those whose source of infection is outside of the body (a) ectogenous, and those in which the elements of infection exist normally in the body (b) endogenous. (Classification of Escherich.)

*Read before the Morristown Medical Club, March, 27, 1907.

The diseases resulting from ectogenous infection are cholera infantum and the toxic diarrhœas. Those from endogenous infection are the commoner forms of diarrhœa from the bacteria existing under normal conditions quiescent in the intestines; but which, under favorable conditions, become virulent. For the primary cause of the chronic gastro-intestinal inflammations we can almost without exception look to the first class, namely, the mechanical irritation, from improper feeding, whether the condition is chronic from the beginning or follows an acute attack. These cases are, as a rule, primarily, non-infectious, but there is always the danger of infection, both from endogenous and ectogenous source.

The majority of the cases of chronic gastro-intestinal disorders are chronic from the outset, but, as intimated above, occasionally they follow an acute attack. Improper feeding or equally poor nursing during the early months of life is the most common etiological factor, as, for instance, weaning the infant to too strong or improper food mixtures, keeping the infant on breast milk which is poor, or, in other words, where the relation of the elements to each other is out of the normal limits, or feeding older infants other articles of food than milk too early, etc. Indigestion is the result of these errors, and unless corrected promptly catarrhal inflammation soon results from the fermentation and irritation of the residue. So, we have inflammation, resulting from indigestion, not from infection; in other words, from the wrong kind of food, or from the right kind of food wrongly administered, not infected or spoiled food.

As the etiological factors of the chronic

gastro-intestinal inflammations are also responsible for the malnutritive diseases, viz., marasmus, rickets, scurvy, etc., there is always a certain degree of malnutrition of one kind or another complicating these conditions, depending upon the degree of involvement, or the amount of interference with assimilation. The infectious diseases may be mentioned as an occasional causative factor.

The early symptoms, and I might say the warning symptoms, are not always recognized, so these cases may be well under way before the true condition is realized. "Colicky baby," "bad" or "cry baby" and "spoiled baby" are terms often applied to infants who are suffering from some serious disturbance. Frequent colic and constant crying and fretting are not natural to the healthy infant. They are usually indications of improper feeding, and it is most important that we should realize this, and recognize these early symptoms and remove the cause as early as possible.

Besides colic, fretfulness and restlessness, stationary weight is an important warning of brewing trouble. There may be little evidence of gastric or intestinal disturbances, and yet the infant does not gain. This is not a normal condition, and as a rule these cases need food adjustment (the cause usually being insufficient food) or malnutrition and digestive disturbances will follow. Other and more positive symptoms relative to the gastric cases, are frequent spitting up, vomiting or regurgitation of sour, watery fluid or milk curds. The baby is restless after feeding and does not go to sleep as it should when well; the abdomen becomes distended, and there is loud eructation. As a rule the infant wants to nurse more frequently, but will only take a little at a time.

The early intestinal symptoms may be diarrhoea or constipation, the former being far more common. In those cases where constipation is the fault, the stools are dry and light-colored, usually being expelled in little balls, with severe straining. Such cases suffer as a rule from considerable colic. Blood or mucus may also be present, usually from the mechanical irritation caused by the expulsion of the stool. When diarrhoea is the early symptom the stools simply become more frequent and loose, but later the character depends upon the element at fault. Yellow, very loose stools, small in size, indicate an atonic condition of the bowels, common in extreme hot weather or in nervous depression from other causes, or when the baby is not getting sufficient

nourishment, as in starvation. Too high sugar percentage may cause such a diarrhoea, but sugar diarrhoea is more commonly green in color. The "scrambled egg stool" or the characteristic fat diarrhoea, yellow in color and containing the soft fat curd; the green indigestion stool, also containing the fat soft curd or tough casein curd, or both; the green color indicating fermentation; the "chopped spinach" stool, with mucus and blood, indications of catarrhal inflammation; very foul smelling stool, indicating decomposition of the proteid principals, and lastly, the profuse colorless watery stool of Cholera Infantum. We seldom see one of these types alone. They are usually in combination, except the last. The stools are very irritating, often causing excoriation of the buttocks (wrongly called sprue).

In well-marked cases, besides these symptoms, referable to the gastro-intestinal tract, there may be the symptoms of an accompanying malnutritive disease. Fever is usually absent except in acute exacerbations. In short, the early symptoms are colic, restlessness, regurgitation, pain, stationary weight and diarrhoea or constipation—simply indications of indigestion. The "chopped spinach" stool, mucus, blood, abdominal distention, tenesmus, malnutrition, etc., are signs of severe catarrhal inflammation. The symptoms may be referable to the stomach alone or to the intestines alone, or there may be involvement of the whole gastro-intestinal tract. In those cases where the stomach is first affected, intestinal involvement, as a rule, very soon follows, but I have seen severe intestinal inflammations with practically no stomach disturbance.

On examination, the condition and appearance of these babies varies considerably, depending upon the stage of the disturbances and the degree of malnutrition. There may be anything from the flabby, peaked, fairly well nourished baby, as in simple chronic indigestion, down to the living skeleton, seen in the extreme cases of severe inflammation with malnutrition and marasmus. The weight is always much below normal and the gain, if at all, is very slow. This is true even in the less severe cases of chronic indigestion. Besides the weight, development is backward. Dentition may be delayed. The fontanelles are slow in closing and in those cases where there is extreme malnutrition there is general muscular weakness, a child of a year often not being able to sit up alone; also anaemia, poor circulation; the hands and feet being cold, often oedema, usually of the

extremities, sweating of the head, the latter being an indication of extreme weakness. The abdomen is distended and hard. There may be enlargement of the spleen. Stomatitis is often a distressing accompaniment. If scurvy or rickets complicate, the pathological conditions of these diseases are present. Meningitis and pneumonia are the common complications, and are quite often the cause of death in such cases.

Many of these cases are simply chronic indigestion, or, as they are called, "difficult feeders," and recover promptly when the cause is removed; but the duration of a well marked case of chronic gastro-enteritis is indefinite. There seems to be no tendency towards recovery. It is usually weeks before any improvement is seen, and even then it takes place only to a certain point; digestion improves, the stools look better, and we begin to feel encouraged, when an acute exacerbation occurs, accompanied by fever and the symptoms return and the child loses in a few days all it has gained in weeks. These attacks usually indicate intestinal toxæmia, but may be simply attacks of acute indigestion, occurring during the chronic condition. They usually occur after the strength of the food has been increased, or during extreme heat, and may prove fatal.

The prognosis of chronic indigestion is good if the condition is recognized early and properly treated. The prognosis of the inflammatory conditions with malnutrition, however, is bad. Some of them finally recover after a long, hard struggle for the child and a most trying time for the parents and physician, but the majority succumb to some complication or die of exhaustion. Many of them go along, up and down, having occasional acute exacerbations, until summer, when a large number are carried off by the first hot spell, and the cause is not infected milk. The cases having the best chances are those among the better classes who can afford change of climate, intelligent nurses, and whose parents appreciate the importance of obedience to instructions.

As to the treatment, by far the most important thing is prevention. Of all the unnecessary and preventable diseases known to the medical profession, these conditions head the list. The origin of nearly every case may be traced to errors in feeding and failure, either on the part of the physician to recognize and correct early warning symptoms; or, on the part of the parent to report digestive disturbances. The curative

treatment is simply a question of feeding and hygienic management. A digestive disturbance, no matter how slight, should receive close attention. A good knowledge and understanding of infant feeding is essential, even in the simple indigestion of short duration; otherwise we will "flounder around" hopelessly, jumping from one food to another, endeavoring to hit on something that will agree, and failing with disgust and in despair, we call for help from the specialist, but it is now often too late.

It is not my purpose to discuss the different methods of feeding at this time. It is enough to say that no two cases are alike and there can be no hard and fast rules. We must feed "symptomatically," if I may use this term. Patience we must have. The progress is tedious and often discouraging. The family and friends will insist that the baby is not getting enough nourishment, and that this is why it makes no headway. The effect of the feeding must be watched, and the strength of food increased most cautiously. It is surprising how little these babies, especially those suffering from the chronic inflammations, can really digest and assimilate, and how little of the right kind of nourishment it requires to keep them comfortably alive. It is that "little" which you must find. If you do they will improve. Be satisfied with every little gain. Do not be too anxious to increase the strength of the food when the baby is doing well.

The hygienic management is important. A change of air is often most beneficial. Exposure to cold, however, must be avoided. Plenty of sunshine and fresh air should be had when possible. Frequent warm bathing is a valuable tonic, followed by massage and gentle friction. In the severe malnutritions olive oil, goose grease or cocoa-butter may be used to good advantage, by rubbing into the skin over the large glands after the bath. I am opposed to lavage and bowel irrigation as a routine treatment of chronic inflammatory conditions. Lavage is only occasionally permissible when there is vomiting of large quantities of mucus, which interferes with the retention of the stomach; and bowel irrigation only when there is severe tenesmus and large quantities of mucus, or when the stools are very foul. This treatment has been much abused. I have had good results, however, from using salt water, one drachm to the pint, by mouth and rectum, for absorption.

The medicinal treatment consists mainly of castor oil, calomel and the supporting

tonics, viz: strychnine, alcohol and in the malnutritive forms cod liver oil when it can be taken. Castor oil is indispensable, bismuth sub-nitrate in full doses is sometimes used to advantage in persistent diarrhœas. I usually combine this with small doses of Dover's powder. When the stomach symptoms are marked, pepsin in some form may be used. Elixir of digestive comp. and elixir lactopeptine are well taken.

After this hurried resume of these conditions, let us consider for a moment what relation they bear to the summer mortality.

Upon looking over the report of vital statistics for the State of New Jersey for the ten years ending December 31, 1905, I find the average yearly percentage of deaths from six important diseases to be as follows:

Pulmonary Tuberculosis	18.5 %
<i>Diarrhœal Diseases of Infants</i>	15.5 %
Pneumonia	9 %
Diphtheria	4.75%
Typhoid Fever	2.25%
Scarlet Fever	1.25%

The average yearly death rate for Morris county alone, from these same diseases, is as follows:

Pulmonary Tuberculosis	9 %
<i>Diarrhœal Diseases of Infants</i>	6 %
Pneumonia	5 %
Diphtheria	2.25%
Typhoid Fever	0.7 %
Scarlet Fever	0.7 %

I would call your attention to the fact that in both of these tables the *Diarrhœal Diseases of Infants* ranks second, and also to the fact that the number of deaths each year from the diarrhœal diseases of infants nearly equals the total number of deaths from pneumonia, scarlet fever, typhoid fever and diphtheria. Now, it is a fact that at least seventy-five per cent. of these deaths from the diarrhœal diseases of infants occur in cases suffering from chronic gastrointestinal disorders, with malnutrition of one kind or another. In other words, the summer is the weeding out time for the babies. It is a case of "the survival of the fittest." Year after year babies are dying, and death certificates are being signed "summer complaint," "cholera infantum," "convulsions," and everybody is satisfied, because babies have always had "summer complaint," "cholera infantum" and "convulsions" and always will have, and it is perfectly natural that they should have.

It is certainly true that there is every year an unnecessary waste of life, and of the most hopeful kind of life, namely infant

life, going on right here in our midst, for there is no doubt about it, many of these summer deaths are preventable. As has been said, the most important etiological factor of infant diarrhœa is faulty feeding. This is the cause of the chronic gastrointestinal and malnutritive diseases which are indirectly the cause of a large percentage of even the infectious diarrhœas, for they produce the susceptible gut, which is an easy mark for infection, whether it be from within, or from without.

We are ever ready to criticise or blame the milk supply; we cry "Pure Milk!" "Clean Receptacles!" etc., and all of this is very important and a step in the right direction, for it is dealing with one of the means of infection, but it is not alone the cause of "summer diarrhœa," and securing clean milk in clean receptacles will not alone reduce the summer mortality. We must bring our babies to the hot months with good digestions and well nourished bodies; for the majority of these summer diarrhœas are not primarily infectious at all, but are attacks of acute indigestion, occurring during a chronic condition and when infection does occur it is from causes within more frequently than from without. This is certainly true in such a locality as ours.

Let us think for a moment of the infants in our practice in the years gone by who have come to the hot months with well nourished bodies and normal digestions; how many have we lost from "summer complaint"? They have had milk from the same sources and as carefully handled as many of those poor babies who have died with this diagnosis. The hot weather lowers the baby's vitality and diminishes its digestive power, also its power of resistance, therefore malnourished babies and those with poor digestions are relatively more susceptible to such disturbances whether the cause be acute indigestion or milk poisoning. An eminent physician in passing through the wards of a well-known babies hospital in New York, in the early spring, pointed to certain babies and turning to his house physician said, "They will not survive the summer." He knew the babies which were in the susceptible condition. Let us think this over and look to those infants in our practice who are in the susceptible condition.

In discussing certain recent research for an anti-toxin, which has been without success, Dr. Chapin says: "One thing prominently brought out by said research was that well nourished infants that had good

digestions were the least affected, while those who were malnourished and poorly fed artificially had the most severe symptoms. Properly nourished infants will not be very susceptible to these infections, and, if attacked, will with proper elimination and dietetic treatment, be able to produce their own natural anti-toxin, which is desirable in view of the fact that each bacillus requires its own specific anti-toxin. The bacteria present in the digestive tract are not harmful when digestion proceeds normally, but if after the curd is formed and the whey containing the sugar is expressed, fermentation takes place instead of digestion, the lactic bacteria have a free field in the whey and the putrefactive bacteria in the curds; products of proteid decomposition resulting from such conditions are apt to be poisonous and cause symptoms of toxæmia. Such diarrhœas should be looked upon as cases of indigestion with a digestive tract filled with fermenting and putrefying food." (From "Theory and Practice of Infant Feeding."—Chapin.)

I do not mean to give the impression that I do not think that there are cases of diarrhœa due to milk infection, nor do I mean that we should let down any in our efforts to procure aseptic milk. We have all seen cholera infantum and the severe toxic diarrhœas, which as a rule are fatal in a very short time, and are due to milk poisoning, but these are not the commonest types of "summer complaint." They are, in fact, rare out here in the country which speaks well for our milk supply. As a preservative to delay changes, when you cannot be sure of your milk, as when traveling, or in extreme hot weather, when the mother is ignorant and careless, sterilization is a safeguard against infection from without and by all means I advise this precaution. In babies with feeble digestion boiled milk will sometimes be taken when fresh milk cannot be tolerated. This is well to remember, as such babies are particularly susceptible to infection, and it removes one source. Through the chemical action which takes place when milk is boiled, certain changes are produced which make boiled milk constipating. This is a desirable action in diarrhœas. We must, however, be just as careful in regard to the modification of boiled milk, for the curd of boiled milk is subject to the same changes within the gastro-intestinal tract as the curd of raw milk. We must also remember that rickets, scurvy, etc., are the result of feeding sterilized milk alone over too long a period. It has been

asked, where should rest the responsibility for these conditions which make the baby so susceptible to the first scorching heat of summer? This certainly cannot be laid to the milkman. I repeat from an article which I wrote several years ago on infant feeding, "It is upon the family doctor that everything depends, for the specialist is seldom called until he is in trouble. His responsibility begins as soon as the baby is born. He should ascertain how the baby is to be fed, and if at any time the mother is unable longer to successfully nurse her baby, see to it that a proper food is substituted—and I mean by proper, one which answers every purpose of mother's milk—and watch with greatest care the results of this food. Impress upon the mother the importance of co-operation, do not order a food and leave it to her judgment as to whether or not it agrees. It takes a very short time to irreparably damage the alimentary tract of an infant. "Country doctors," as we are called, have a tendency to be satisfied with a rather superficial knowledge of infant feeding, and the conditions resulting from faulty feeding, most of us have a pet formula and if this does not agree we are lost. We think scientific feeding is somewhat bosh; a busy man has not time to bother to show mothers how to make baby foods; the mother ought to know this herself. We are inclined to expect too much from nature, and we are apt to think that these conditions are only prevalent in large cities. This is erroneous. We have fewer cases, true, but comparatively our percentage is as high.

Dr. A. B. Keys, in a lecture delivered in Chicago some time ago, said, "What does proper infant feeding prevent?" "(1) It lessens the number of cases of, and especially the mortality from, acute intestinal and infectious diseases; (2) it avoids the distressing conditions known as malnutrition, rickets, marasmus, scurvy, etc., from which a large number of children die annually; (3) a large number of cases of tuberculosis, especially of bone in children are predisposed to the disease by the chronic gastrointestinal inflammations: in which condition the tubercular bacillus gains access to the circulation; (4) proper infant feeding is a necessity for the good health and the character of the child, that later will become the man, and this is the perservation of the health and character of our nation."

The time to treat our cases of summer complaint is all the year round, by giving close attention to the food of every baby in our practice, breast fed or artificially fed.

Those babies who will not be able to nurse through the summer should be weaned in good season, and well started upon a proper substitute food. All chronic gastro-intestinal irregularities should be corrected, no matter how slight they may seem.

Children suffering from malnutrition, rickets, scurvy, marasmus, etc., should receive energetic treatment. The poor, especially, need our help. Teach the mother the importance of bringing her baby to the hot weather in good physical condition. Show her how to make the food. Write all directions and be explicit. Of course, inform her of the importance of keeping her milk on ice in hot weather, and if this is impossible show her how to preserve it. Teach her the importance of cleanliness: the importance of getting good milk from an honest dealer; and the most important thing of all to send for you when anything goes wrong with her baby, to take the advice of no one and not to change the baby's food without first consulting you. This effort on the part of every doctor, all the year round, will be a big step towards cutting down the mortality in our county from "summer complaint."

REPORT OF CASES.

The following four cases were seen by me in private practice. They are interesting in that they represent and illustrate very nicely four typical phases of chronic gastro-intestinal disorders, and also demonstrate the fact that we do have considerable of this trouble, even in Morristown.

CASE NO. 1. Baby S. Age seven months; previous history: breast fed for four weeks, after that Holt's formula, Florham Farms milk being used; food said to have agreed satisfactorily. There had been, however, occasional attacks of indigestion, and gain in weight was below normal. In July, at the age of five months, the baby had an acute attack of "summer complaint." Very ill for two weeks, but finally recovered and was started on Winter's Cream Mixture. On the second day after this food was started, vomiting, diarrhoea and high fever returned with all the symptoms of acute inflammation. This time the child showed no tendency to improve. The stomach remained unretentive, and loose green stools full of mucus continued five to ten every day. A specialist was finally called and took charge of the case, the parents moving with the baby to New York. At this time the child had a well marked chronic gastro-enteritis. The treatment un-

der the best of conditions availed nothing, and on October 1, 1905, the child was brought back to Morristown to die. I was called to help it die. In other words, to relieve its suffering and make death easy. During its stay in New York stomach washing and most careful feeding, partly through the tube, under the direction of several of the best known "baby" men in the city, were resorted to.

I saw this case first on October 2, 1905. At that time the stomach was unable to retain a teaspoonful of nourishment at a time, it had to be fed with a medicine dropper. The child was seven months old and the weight, eight pounds. I stopped the stomach washing at once, also the milk and gruel feeding, and in desperation ordered some mutton broth free from fat and very salty. The baby took this readily, taking six ounces and retaining it; the first nourishment of any amount it had retained in over four weeks. I mention this part of my treatment as it was out of the ordinary, and may be of some interest. The child lived until the following May, 1906, and was apparently doing well. It died very suddenly. At the time of its death it was taking a milk formula, 3—6—1, with barley gruel dilution. It had gained four pounds, weighing now over twelve pounds. This was a typical case of severe chronic gastro-enteritis with malnutrition, as a result of an acute attack and occurring in a baby whose milk was as good as could be had, living in the best of circumstances. She would probably have recovered from the first acute attack, however, if the high cream mixture had not been given so soon.

CASE No. 2. Baby C. Age two months; previous history: Breast fed five days, mother said her milk was poison to her other babies, so with the consent of the attending physician she weaned to Patch's Sugar of Milk. Baby lost weight from birth. Stools were always green and loose; vomited frequently. In spite of these symptoms the food was continued for three weeks, when the child had a convulsion. The doctor was called at this time, being the first time he had seen the baby since ordering the food. He put the baby on condensed milk, but, doing no better, changed to Peptogenic Milk Powder in a week; results no better. I saw baby first on September 6, 1906, at the age of two months. Condition at that time was as follows: Cried constantly, was very restless, rolling its head from side to side; slept little; evidently hungry and in pain; weight six

pounds; face and body wrinkled; abdomen distended; stools green, loose and full of mucus and some blood; five to ten each day; vomited after each feeding; temperature sub-normal. Baby died September 16, showing no improvement. This case was one of chronic gastro-enteritis from the first, due to improper feeding. It demonstrates the result of neglect, on the part of the attending physician, to pay attention to the baby during the post partum calls, and is remarkable in that three proprietary infant foods were prescribed by the physician before the baby was six weeks old.

CASE No. 3. Baby M. Age seven weeks. Previous history: Breast fed from birth, mother's health not the best, but had large quantity of milk, running constantly from breast. The child, never from the first, seemed happy after nursing. Cried constantly; slept little. Had a great deal of colic, passing gas from the stomach and bowels; stools always more or less green and contained small white tough curds, loose and frequent, from three to eight a day. Vomited frequently large quantities of sour liquid, usually soon after nursing, probably due to rapidly overfilling the stomach, as the milk ran from the breast without much effort on the part of the baby. Had gained about a pound since birth. I saw this baby first May 1, 1906. Examination of mother's milk showed the percentage of proteids to be far too high (six per cent.) and the fats much below the normal limit (one per cent.). I recommended weaning to modified milk, and told the parents of the seriousness of the condition. This baby was taken to the seashore, and through careful management under a specialist of large experience, and a competent nurse, recovered after about six months of suffering for the child and of terrible anxiety for the parents, having several severe acute attacks during this time. This illustrates a case of chronic gastro-enteritis from the outset, occurring in a breast fed baby in the best of circumstances; also the importance of early recognition of serious symptoms.

CASE No. 4. Baby G. First baby. Age eight and one-half months. Previous history: Breast fed for five months, but did not seem satisfied, so condensed milk was ordered in connection with breast. This increased the number of stools, so barley water and cow's milk were tried, half barley water and half whole cow's milk boiled together was given. The baby did not like this, so breast feeding was resumed. This was continued until eight months of age,

the weight at this time being fifteen pounds; three months ago at the age of five months it was fourteen and one-half pounds. The stools for the past five months had been frequent, and never anything but loose yellow water. There had been, however, at no time any symptoms of indigestion. The mother's menstruation returned when baby was five months old. Baked potatoes and soft boiled eggs, also zwieback, were suggested as additions to the diet. I saw this case first January 16, 1907. Age eight months, one week. The baby was poorly nourished, very small, had no teeth nor any signs of any; weight fifteen pounds; stools were yellow and very loose and frequent; except for yellow discoloration of diapers one would hardly know the baby had had a stool. Examination of mother's milk showed it to be fair in quality but very scant, the breast being small and flabby. It is quite evident that this baby had not been getting sufficient food during the past three or four months, and as a result there was malnutrition and interference with the natural development of the digestive organs.

This condition is a dangerous one and the baby was eligible for "summer complaint." I believe that this baby should have been weaned three months ago at least and given a proper food mixture; the stationary weight, returning menstruation, previous history and examination of breast and milk being sufficient cause.

The lesson which we may learn from this case is the importance of watching the progress of breast fed as well as bottle fed babies, the importance of recognizing symptoms of faulty feeding. This case was literally one of starvation. It also illustrates the importance of writing explicit instructions for feeding, and of having the mother report every day, if necessary, the result of the food prescribed. I do not believe in eggs or potatoes in any form for babies of this age.

Gradually increasing jaundice without previous history of pain, or with a history of very slight pain, is very suggestive of malignant disease.—*Amer. Jour. of Surgery.*

There is one point that must always be thought of when pus has been aspirated after an exploratory puncture for either suspected empyema or liver abscess; make sure that the "pus" does not come from a bronchus. This can be determined, as a rule, by microscopical examination of the aspirated fluid.—*Amer. Jour. of Surgery.*

SOME EVILS BESETTING MEDICAL PRACTICE.*

By Linn Emerson, M. D.

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morial Hospital.*

Every human being is prone to envy his more fortunate neighbor. In many instances, his neighbor's more fortunate condition is more apparent than real. It is not my intention to decry the profession of medicine, but rather to appear as an optimist than as a pessimist. George Eliot in *Middlemarch* says that every clergyman and every physician should feel that his profession is the very best in the whole world. The physician is to be pitied who would not have his son follow in his footsteps; citing as his reasons the hard work, long hours, loss of rest, and poor compensation. He himself has missed his calling. What drudgery medical practice must be to the man who does not love his work, for the work's sake.

President Faunce of Brown University in a recent address before the Rhode Island Medical Society says: "In two respects the medical profession deserves the grateful recognition and regard of all other callings in modern life. It has always been insisted that the practice of medicine is a profession, and not a trade. Trade is occupation for livelihood; profession is occupation for the service of the world. Trade is occupation for joy of the result; profession is occupation for joy in the process. Trade is occupation where anybody may enter; profession is occupation where only those who are prepared may enter. Trade is occupation taken up temporarily, until something better offers; profession is occupation, with which one is identified for life. Trade makes one the rival of every other trader; profession makes one the co-operator with all his colleagues. Trade knows only the ethics of success; profession is bound by lasting ties of sacred honor."

There is little doubt that a large percentage of the more successful practitioners of medicine would continue practice even if possessed of independent means. That the practice of medicine is not a money-making proposition is too obvious a

fact to require comment. Any young man who chooses this profession in the hope of acquiring independent means is doomed to disappointment. I have no knowledge of any physician leaving a large estate, who had not either inherited his wealth or acquired it in channels outside the lines of medical practice.

The general public expect from the clergyman and the physician the highest standards of character, and may it be said to our credit they are not often disappointed. Since every profession must bear the odium of the acts of its individual members, it behooves each of us to so conduct himself that the profession as a whole be not injured in any way whatsoever in the sight of the public. This is one of the reasons why we have fought so vigorously for many years for higher educational requirements for admission to our ranks. It is to be hoped that the day is not far distant when no man will be admitted to a medical school who is not possessed of a college degree. As a sign of progress in this direction, I note with much satisfaction that eighty-seven per cent. of the men now in the Harvard Medical School are possessed of a college degree. Those who object to such rigid requirements, claim that many deserving and capable men would be thus excluded for lack of funds and time to pursue such a necessarily long period of study in preparation for their life work. Conceding this, to be true, does there seem to be any danger that such requirements would cause a dearth of suitable material to swell our ranks?

While hardship and injustice might thus be wrought in certain instances, is there any doubt but that such rigid requirements would be of great advantage to the public at large, and to our profession as a whole? A careful analysis of "Who's who in America" has shown that in any one of the three so-called liberal professions a man's chances of becoming eminent are six times as great if he possesses a college degree, and the reviewer concludes that such degree is of least value to the lawyer, of next value to the clergyman, and of greatest value to the physician. In other words, the doctor who possesses a college degree is eight or nine times as liable to have his name appear in "Who's who" as his less fortunate brother. While we have made rapid progress during the past two decades, I feel that one of the evils of medical practice is still insufficient preliminary education. In view of our long struggle for better educational re-

* Read before the Practitioners' Society of Orange, June 22, 1906.

quirements, and the fact that we have thousands of physicians who are deficiently educated, what a travesty it seems that several of our State Legislatures have recently passed laws putting the osteopath, whose attainments are no more than par with the physician of fifty years ago, on a footing with the graduate of Harvard or Johns Hopkins.

The college graduate, as a rule, has a higher appreciation of the value of a long medical course and a hospital internship; he is much more liable to undertake a regular medical course than to attempt to sneak in the back way and become an osteopath, magnetic healer, Christian Science healer, or follower of some other "apathy" or "ism," and should he become a full fledged M. D. is far less liable to degenerate into an irregular or a quack, than the man recruited from the ranks of "the butcher, the baker and the candlestick maker."

One of the greatest evils of our profession, and one which gives the osteopaths their strongest lever, is the fact that we are a divided house. Of the earlier differences between the homeopathic and regular schools (and here let me say that we of the regular school are not allopaths, and I trust no self-respecting physician of the regular school will permit any person to designate him as such without denial and correction) the less that is said the better. The main difference in the practice of the two schools is in the matter of therapeutics, and the wiser members of our profession are rapidly growing to learn that the giving of drugs is after all only a small part of intelligent medical practice.

There is nothing in our present code which prevents any physician from practising in any manner he may see fit, whether it be by the methods of homeopathy, osteopathy, or mental therapy, provided he does not pose as a healer of some particular kind or sort, and discountenance all other methods of practice. The true physician should be a man of open mind, and possess an acute faculty of discrimination, which enables him to make use of every method and procedure known to the profession. Homeopathy has accomplished the good for which it came, in revolutionizing dosage, but the dogma of "similia" remains "not proven." At least, this is the opinion of more than ninety-five per cent. of the medical practitioners in the world at the present day. It has had, like vaccination, more than one hundred years in which to convert the profession, and to-day it is losing ground steadily. If certain

members of the cult sincerely believe in it, they should certainly be permitted to use it in their practice, but to assert that it is the only true way is dogmatism to the degree of "puppyism grown up." Differences of opinion will always prevail.

About one hundred years ago the president of the Royal College of Surgeons, in his annual address, stated that surgery had attained the acme of perfection, and no further improvement need be anticipated. This was before the discovery of anesthesia or antisepsis, and the surgeon of to-day is prone to smile at the self-complacency of our brother of a century ago. There is no doubt that the union of all schools of practice under the name of "physician" would be the ideal condition, compelling all to meet the same educational requirements, and permitting every individual who was in possession of the requirements to practice his profession in whatsoever manner he saw fit. If suitable *preliminary* requirements were exacted, there is little danger that the profession, or the public, would suffer thereby. In my opinion, the members of the regular school should extend the olive branch to the homeopaths, conceding to them their ideas of drug prescribing, that we may all be united under one banner, for the good of suffering humanity.

Not only has our profession been divided, but until recently there has been little or no organization or co-operation even among the members of our own school. As a result, quackery has flourished like a green bay tree, and the patent medicine evil has grown to such proportion that the lay press in the person of *Collier's Weekly* and *The Ladies' Home Journal* have taken up the cudgels in behalf of the deluded public. Stimulated by their example, our official journal has taken up the subject with much greater activity and vehemence than ever before; the membership of the American Medical Association has grown so rapidly and we have fought so vigorously for ourselves and for the public during the past two years, that the official organ of the Proprietary Association of America in recent scare editorials made reference to the "Doctors' Trust." In reply, instead of denying such a trust, let me ask is it not about time we had a "Doctors' Trust"? The various combinations of capital and labor practically control the price of every article we buy to-day. The clergy and the legal profession are far better organized than are we, and is it not to our discredit that we have been so apathetic in the past as to permit the

world at large to ride over us rough shod? Imagine an employer arbitrarily cutting the wages of any class of artisans forty per cent., as the life insurance companies have recently done for medical examinations, of druggists for so many years without active protest, and in many instances have continued to permit our patients to go to

Is there not a field for a druggist who will do prescription work alone, and if such a store were started would it not be our duty to support it, and send it all our prescriptions? In the past we have been too afraid of giving offense for fear of losing work. We have been lacking in courage, and have not conducted the business side of our profession along business lines. Throughout the world, doctors are known as poor business men, and by the book agent, the speculator, and the man with something to sell, he is regarded as "easy money." The best investment a doctor can make of his time is to join his county, state, and national society, and to further the interests of his profession in every way possible by his activity and presence in these societies.

Many a business man has failed because "he could not see a dollar unless it was coming his way." Such men fail to see the value of advertising; fail to see the advantage of business men's associations. With the manifest advantages of organization seen on all sides, who can question that our profession would be in a much more enviable position if we were better organized. Despite this fact, less than one-fifth of the profession in this county possesses membership in our national body. The doctor who does not join because he can see no advantage to *himself* is like the short-sighted business man who can not see a dollar unless it is coming his way. He does not realize that a well-organized profession means a more prosperous profession, and that a prosperous profession, as a whole, means greater prosperity to its individual members.

It is gross neglect on the part of our medical schools that the senior class does receive at least one lecture on the advantages of organization, and that its members are not urged to join their local society as soon as they enter practice. Another point on which our medical schools are woefully negligent is in instruction in the ethics of medical practice. It has been said that the ethics which govern medical practice should be the ethics which govern one gentleman in his relations with another, and that the "Golden Rule" is all that is required. While

this is no doubt true, we are but human, and a gentleman is said to be "a man whom all other gentlemen concede to be a gentleman"; therefore, few of us are up to the standard. Without seeming to be prejudiced, it would seem to me that the elder members of our profession are the worst offenders in the matter of ethics, particularly so since not only the act itself is to be considered, but the influence it may have on our younger members. As a young man, I may say that I can recall no act of professional discourtesy from a man of my own age, but I can recall many from men older in the profession.

This is no doubt due to thoughtlessness in most instances, but there is often a feeling among the elder members that the young man is a sort of trespasser. The code of ethics has been designated as "a fence erected by the old fellows to keep the young fellows out." To be sure, it is very aggravating to the practitioner of mature years to see many of his patients going over to the progressive and energetic younger man (whom he often considers a conceited youngster) but he should remember that not only he and his rival suffer by any act of discourtesy, but also the profession, as a whole, in the eyes of the public. In Kingsley's "Water Babies" you may recall how the poor sweep looked forward to the time when he would be a boss, and pictured how he would kick and cuff his poor apprentice about, even as he was then kicked and cuffed about. Is it not possible that a little of this worldly spirit pervades even our own noble calling? While a college student, two members of the faculty of my alma mater were scarcely on speaking terms with one another and two of the most eminent ophthalmologists in this country are on such bad terms that they go out of their way to speak ill of one another to their patients. If these men could realize the injury they are doing the profession as a whole by their pernicious influences on its younger men, I feel sure they would have learned that silence is golden.

Another evil for which the elder members of our profession are at least in part responsible is the so-called hospital abuse or evil. The "big gun" sees but two classes of patients: Those who can pay his large fees, and those who can pay nothing. He gobbles the former in his practice, and runs the others into the hospital, treating them for nothing. He seems to have forgotten that he was ever a young, struggling practitioner, glad to make house calls for \$1.00, and treat patients in his office for fifty

cents. Many hospitals do not permit their visiting doctors to charge for ward cases, and if the doctor is to receive payment the patient must take a private room. A patient who can afford to pay \$25 for a minor surgical operation is not a pauper, and it is an imposition upon the doctor to ask him to operate for nothing, and have the hospital take all the patient can give. The hospital gets practically *all* the credit for the medical charity it performs, whereas in many instances the patients pay the hospital for their board and the doctor who actually performs the act of charity gets little or no credit. Does not the doctor do enough for the hospital without relinquishing his just fee? The chief, or visiting surgeon, has so much business he does not care for this sort of cases or the fees they may bring, but he is remiss in his duty to the profession and to his younger or less fortunate brother in countenancing this condition of affairs.

In some of our large city hospitals the assistant surgeons are constantly on the lookout to violate the rules of the institution and steal patients from the clinics. This is due to the fact that they doubt the sincerity of the board of surgeons who claim that proper steps are taken to exclude the unworthy. I have personal knowledge that the chief surgeons themselves have been guilty of taking cases from the clinics to their offices, and it has been jokingly said that Andrew Carnegie himself could get free treatment without question at some of our hospitals if he would "put a little money in the box to help the hospitals." This comports with the fact that the managing board laymen, who have no interest or care for the welfare of our profession, are in the majority, and to the failure of the chief surgeons to safeguard the best interests of our profession. As a result of this, a profession that does more for charity than any class of men in the world is imposed upon and defrauded of much of its just income, and, what is still worse, gets little or no credit for it.

The remedy? *Organization!* If the medical profession were properly organized, the spectacle recently witnessed at St. Joseph's Hospital, Paterson, would be an impossibility.

While there are many other evils in our profession which I shall not mention, I hope

I have said enough to convince you that the greatest of all our evils is lack of union. Let us all not only join our State and National Bodies, but go out into the highways and byways and influence our colleagues (particularly the younger men in the profession) to do likewise.

EYE SYMPTOMS OF AFFECTIONS OF THE ACCESSORY SINUSES OF THE NOSE.*

By Charles F. Adams, M. D.,
Trenton, N. J.

The eye symptoms caused by sinus disease are many and not characteristic enough to be diagnostic of the nasal accessory sinuses, but they can be of much use in conjunction with other symptoms. To make the subject interesting it will be necessary to consider it as a whole, viz., the sinuses, their relation to contiguous parts, their symptoms, that can be recognized by the general practitioner, and their treatment.

First, eye symptoms, or symptoms that could be caused as well by diseases of the eye: frontal and occipital headache, heaviness and a feeling of fulness with pressure between the eyes, temporal pain, dizziness, mental depression, ptosis, exophthalmos, swelling of either upper or lower eyelid, or at inner canthus resembling a dacryocystitis, swelling and engorgement of conjunctiva, photophobia, contraction of the field of vision and optic atrophy. A truly varied assortment of symptoms by none of which, of itself, could a diagnosis be made.

Acute sinusitis may occur, in connection with a cold in the head, either as a direct infection or by a swelling of the mucous membrane damming up the secretions, or traumatism. The symptoms are usually pain over the sinus, with swelling of adjacent tissues.

This morning a woman called to consult me whom I had seen a week before, at which time the conjunctiva of her right eyeball was red and swollen and the cystic duct in like condition, with the tears running over her cheek. She told me that it came on suddenly in the night. I examined the nose and found the left nostril normal, the right one the turbinates greatly swollen and pus coming from the ethmoid. The parts were cleansed with adrenalin solution—1/2000—and 5% cocaine solution, and I told her to report the next day. She was also under

* Outline of an address delivered before the Mercer County Medical Society, March 12, 1907.

treatment for an ocular palsy and a beginning choroiditis, and was in the habit of calling about once a week. I didn't see her again until this morning. Her eye had regained its normal appearance, and the nasal swelling and discharge had nearly disappeared—a much quicker termination than usual.

In chronic sinusitis the location of pain is not of much value. Supra-orbital pain may be from the antrum rather than from the frontal sinus. In ethmoidal disease the pain is referred to the bridge, or post-orbital region. In necrosis crepitation can be felt at the inner angle of the orbit, exophthalmos and contraction of the visual field. It may open at the inner angle of the orbit, resembling dacrocystitis, neuralgic pain aggravated by blowing the nose, which reminds me that in the case just cited, the swelling greatly increased after first blowing her nose in the morning, a sensation of dulness and weight, sometimes exophthalmos and swelling of the upper eyelid, orbital abscess.

In sphenoidal disease pain is frequently referred to the back of the head, ocular symptoms from involvement of the trigeminus, ptosis, etc. Impairment of sight and exophthalmos. It may readily extend to the orbit or meninges, or erosion of cavernous sinus with fatal hemorrhage. The following case illustrates the damage that can be caused by an infection of the sphenoid:

R. D., aged 21, called to see me in 1900; four years previously had an attack of the measles, followed by symptoms described by him which doubtless indicated a sphenoidal sinusitis; accompanied with a copious discharge of pus from the posterior nares. Since that time he has been blind. Right eye light perception; left eye can count fingers at three feet; disc atrophied, retina pale, atrophic choroid. Last December he called again and, although so near blind, he said he had been working as a "core" maker in a foundry, and lately in going from the dark foundry to the street, he would see flashes of light. On examination small new spots of choroiditis were observed. He was given small doses of K. I. and he returned in a month with the flashes of light symptoms relieved and his vision as before.

Antrum, the normal opening above the inferior turbinate, is much higher than the floor, therefore an inflammation is accompanied by much swelling and pain in the adjacent parts, and is quite as frequently caused by an abscess of the root of a lateral incisor, as by some nasal disturbance. Some of the symptoms, to recapitulate, are nasal

suppuration, pain, bulging wall, carious tooth, darker by transillumination, aspiration.

An illustrative case: G. H., aged 18, January 29, 1907, student, eyes pain on attempting to read; two days before had a toothache in right second molar of upper jaw; yesterday morning right eye began to pain so that he could not read; photophobia, supraorbital nerve tender to pressure, right turbinates congested and swollen; applied 20% cocaine to nares and quinine sulph. 2 grains every two hours. The next day there was more swelling of lids and the second upper molar sensitive; examined by a dentist; result, negative; applied cocaine and weak iodine solution to nares, and told him if he was not much better in the morning I would wash out the antrum, but the next day he was better and in a few days entirely recovered.

To-day I operated on a little fellow with the following history: H. M., aged four and a half years; on New Year's day had toothache in left upper jaw, which caused the cheek and eyelids to swell very much; in two or three days the mother extracted the tooth; to-day there was a pus discharging sinus opening 3 mm. below the lower lid; the sinus leads to the antrum. In the mouth the first molar is pushed up into the alveolar process even with the gum; looks like a spot of pus from a discharging sinus; the second molar was extracted by the mother; operation, curetted upper sinus, extracted first molar tooth and found the alveolar processes spongy and necrosed for 2 centimeters back and up; could find no sinus leading to the antrum, but in curetting backward was led into the antrum by the soft bone; cleaned it out well, swabbed with carbolic acid, and packed lightly with gauze; fastened a gauze dressing on the external opening.

Pus on the inferior turbinate is most likely from the antrum; on the middle turbinate from the frontal sinus or ethmoid, and in the posterior nares from the sphenoid. Treatment: Reduce swelling of mucous membrane and obtain free drainage; normal saline solution, weak tincture iodine, cocaine 5% or 10% and adrenalin chloride 1/1000, will reduce the congestion. For drainage of antrum for acute cases that do not resolve quickly puncture with a straight canula 2 mm. in diameter, insert 7 mm. or 8 mm. under inferior turbinate; then point at the floor of the orbit with the distal end against the septum; there you will find a small opening in the bony wall covered only with fibrous tissue and mucous membrane;

scarcely any force is required to penetrate this thin membrane; inject saline solution in with a 4-oz. syringe, and it will flow out of the normal opening, carrying with it the accumulated pus. If it is not cured in four or five weeks, open the gum above the second molar.

For drainage of the frontal and anterior ethmoid, remove the anterior portion of the middle turbinate and tear out two or three cells of the ethmoid with a short, pointed, dull hook. For the sphenoidal sinus remove the posterior end of the middle turbinate and enlarge the normal opening with a sharp short, pointed cutting hook. These sinuses are then to be treated as directed in the treatment of the antrum. In treating a sub-acute catarrh of the nares, if cocaine is applied too strong it will excite an acute coryza.

Reports From County Societies.

CAMDEN COUNTY.

Henry H. Sherck, M. D., Reporter.

The Annual Meeting of the Camden County Medical Society was held in the dispensary building, Camden, N. J., on April 23, 1907. The following officers were elected to serve during the ensuing year: President, Dr. Sylvan G. Bushey; Vice-President, Dr. Paul Mecray; Secretary, Dr. Daniel Strock; Treasurer, Dr. A. Haines Lippincott; Historian, Dr. Alfred Cramer; Reporter, Dr. Henry H. Sherck; Censor, Dr. William Westcott; Trustee, Dr. E. L. B. Godfrey; Legislative Committee, Drs. H. H. Davis, Paul N. Litchfield, Wm. A. Sprenger. The retiring President, Dr. Joel Fithian, read the annual address, the subject being "My Experience in the Treatment of Eclampsia," which was listened to with rapt attention by all present.

The committee on post-graduate course reported favorably and will commence its work on the second of May, 1907. One of the pleasant features of the meeting was the presence of Drs. Chas. Braddock and E. L. B. Godfrey, Dr. Braddock having just returned after a five years' absence in far-off Siam. Dr. Braddock held many important positions under the Siamese government. As a reward of his good work the King of Siam bestowed upon him the order of the "White Elephant." Dr. Godfrey was also given the glad hand on his return from the Pacific coast, whither he had gone to recuperate his health, and we are pleased to report that with health restored he will resume his professional work.

The meeting was well attended. Several visitors from nearby counties favored us with their presence.

CAPE MAY COUNTY.

Marshall F. Lummis, M. D., Reporter.

The Annual Meeting of the Cape May County Medical Society was held at Cape May April 2d with good attendance. It was decided to discontinue quarterly meetings and return to semi-annual sessions because of the lack of attend-

ance of members who seemed unusually busy on the days of our meetings.

Two new members were elected—Dr. Margaret Mace, of Anglesea, and Dr. H. H. Tomlin, of Wildwood. Dr. D. King Webster, who during the past two years has been out of the State, having returned, was reinstated.

The following were elected as officers for the ensuing year:—President, Nathan A. Cohen, Wildwood; Vice-President, George W. Geyer, Cape May C. H.; Secretary, Marshall F. Lummis, Holly Beach; Treasurer, Randolph Marshall, Tuckahoe; Censor, D. King Webster, Cape May C. H.; Reporter, M. F. Lummis, Holly Beach; Delegate to the State Society, J. Morgan Dix, Cape May C. H.; Permanent Delegate, Randolph Marshall, Tuckahoe.

The remainder of the session was occupied in discussing plans for the entertainment of the State Society during their annual meeting at Cape May in June.

The Society has on roll at present twenty-three members in good standing.

On the evening of February 23d Dr. J. N. McCormack addressed our County Society at Cape May and afterwards made a very interesting address to the public.

CUMBERLAND COUNTY.

Stacy M. Wilson, M. D., Reporter.

The Annual Meeting of the Cumberland County Medical Society was held at City Hotel, Bridgeton, on April 9. There was a good attendance of members present and an interesting meeting. The following officers were elected for the ensuing year: President, E. S. Corson; Vice-President, John C. Loper; Secretary, A. J. Mander; Treasurer, Joseph Tomlinson; Reporter, S. M. Wilson.

An essay on "Pneumonia in Children" was read by Dr. J. C. Loper and was generally discussed.

The subject of decreased fees for life insurance examinations in the ordinary and the small amount paid for industrial work was unfavorably commented on by a majority of the members.

The Society has met with a loss in the death of Dr. Henry W. Elmer, one of its most active members, up to the time of his affliction ten years ago. Dr. Elmer graduated from the University of Pennsylvania March 13, 1869, and died on February 13, 1907, within one month of his thirty-eighth anniversary of graduation. A committee was appointed to draft suitable resolutions commemorative of his worth and service.

Dr. Leslie L. Hand, of Millville, who has been the efficient Secretary for the past two years, has retired from the practice of medicine and entered the active ministry, having been given an appointment on the New Brunswick district at the recent session of the New Jersey Conference of the Methodist Episcopal Church.

The next quarterly meeting will be held in Millville.

Bridgeton, N. J., April 22, 1907.

HUDSON COUNTY.

August A. Strasser, M. D., Reporter.

The regular meeting of the Hudson County Medical Society took place in Jersey City on April 2. Dr. F. D. Gray presided. After routine business had been accomplished, the following clinical histories were reported and discussed. Dr. Culver related the case of a girl thirteen years of age, who was inordinately fond of roller skating. After an afternoon's sport the child came in com-

plaining of feeling dizzy, and having noises in the left ear. The pulse was accelerated, but temperature was 99° Fahr. rectally. From the history and subsequent symptoms, the diagnosis of Menière's disease of the semi-circular canals was made. The doctor pointed out that perhaps the etiologic factor in this case was not so much the roller skating as the fact that frequent severe blastings in the neighborhood may be held accountable for the lesion. Under the treatment with initial doses of strychnine and potass. iodide improvement was marked. Dr. Sweeney reported the case of a woman who complained of sudden pain and tendencies in the epigastrium. Palpation was negative. Later the pain shifted downward further into the right iliac region and then a tumor was mapped out adherent to the liver. Patient's temperature was only 99° Fahr. rectally and pulse 88, but vomiting was obstinate. Laparotomy discovered an inflamed gall bladder six inches long and containing seventy-five gall stones. This was therefore a case of cholecystitis and cholelithiasis, without previous history. Dr. Faison reported the case of a man from Porto Rico, who, with good appetite, and no vomiting, had a tumor in left hypochondrium; an exploratory incision revealed the tumor to be cancerous, but strangely it had given no symptomatology or evidence of its existence. This was in the cardiac end of the stomach, as, in fact, recently Dr. Faisson had had a run of cardiac involvement in gastric growths, his proportion up to date being 5 to 3. Dr. Strasser reported two cases. One of a child that had come to the clinic with a history of very recent true obesity. Family history was negative, but personal history, as shown by photographs, showed a normal child up to the fourth year, when there was a slight exophthalmos. Then a year ago the child began to grow stout and develop lipomatous masses over the cervical region posteriorly and over clavicles. Her measurements were much beyond her age, e. g., bust and abdominal measurement was 30 inches each in circumference. The question was whether or not a myxedema was underlying the condition; but the fact that the hands and skin perspired freely, and that the child was bright and up to the grade in school, failed to corroborate that. Of course, there was some disturbance of metabolism, but its cause was problematical. The second case was one of Cæsarean section, on a primipara, 33 years old, with undilated cervix, whose membranes had ruptured a week before and in whom the presentation of the child was a right evento-posterior. Mother and child living and recovered. Dr. Spence reported a case that had passed through a number of operations. Firstly the left ovary was removed; later the right ovary was removed, so it was alleged, in part; several weeks ago abdomen was opened again and remainder of right ovary was said to have been removed, and the surgeon said that the appendix should have been removed, but not having been authorized to do so, it was left. Then Dr. Spence performed appendectomy, removing a long appendix, fibrous at both proximal and distal ends, dilated in the center and containing a fecal concretion; the tip of the appendix was adherent to uterus. Likewise he found either a supernumerary or remaining part of right ovary which had become cystic. Dr. Lampson detailed a straight case of glycosuria with rapidly fatal termination in diabetic coma. Dr. George E. McLaughlin reported the case of a woman who had had the tube removed on one side and the ovary of the other, and in whom

nevertheless pregnancy supervened, and expressed his conviction from this and other cases studied that impregnation of ovum occurred in the ovary rather than in tube or uterus. Also a second case of Hodgkin's disease that came to autopsy, where the complete tubercular degeneration of the suprarenal glands was demonstrated. Dr. Helfer reported a case of attempted substitution in life insurance examination, a healthy brother impersonating his brother who had an endocarditis, in which the difference in signatures given to the agent and in the presence of the physician was the clue that led to the detection of the attempted fraud. Dr. Nelson related visiting a child that was comatose and in whom the former diagnosis of broncho-pneumonia had been made. Child had no temperature, however, but in taking this a tremendously enlarged scrotum was found. A history of anuria and general anasarca was elicited. In attempting to stretch an existing phimosis, a concretion was felt blocking the urethra. Removed it and improvement followed. Dr. Rosenkrans detailed the history of a child four years of age, with a severe croupy cough, but no demonstrable lesion. Temperature was 100° Fahr. for ten days, when sudden dyspnea called for intubation. Anti-toxin was administered, with recovery, but infection of a sister occurred a week later with typical lesions of diphtheria. Dr. Gray, commenting on puzzling cases, related a case that he had seen in Vienna. A Turk presented himself with a large abdominal tumor that was diagnosed as an undescended testis. Operation showed a tumor the size of a child's head that proved microscopically to be uterus and adnexa, while the ovary of this was histologically a testis; a true case of hermaphroditism. Equally puzzling at first was a case he saw a week ago. She was 35 years old, had one leg swollen from hip to ankle to the circumference of at least thirty-two inches; the skin was hard and brawny. Diagnosis. elephantiasis. Filaria not demonstrable; eighteen years ago had had malaria; operative treatment was claimed to be effectual, but had been refused. Dr. Nelson then read the paper of the evening on "Diarrhoeal Diseases in Children." Drs. Sweeney, Parsons and Gray discussed the paper.

The Committee on Legislation reported the work done at Trenton in re the osteopathic bill, and the passage of the Frelinghuysen Compromise bill was urged as a solution of the constant annual fight to debar this form of quackery, and to restrict it to the field it can legitimately handle. Other routine business was disposed of and the following officers elected for the ensuing year: Dr. F. D. Gray was re-elected president; Dr. J. J. Mooney elected vice-president; Dr. A. P. Haskings, secretary; Dr. Brinkerhoff re-elected for the fourteenth consecutive year as treasurer; Dr. Culver as censor; Drs. Helfer, Parsons and Bowman as permanent delegates to the State Society and Drs. Blanchard, Faison, Rue, Everett, Spence, Sweeney and Rosenkrans as annual delegates. Dr. Strasser was reappointed reporter. A committee was appointed to arrange for the annual dinner, and instructed to have it take place in Hoboken.

SOMERSET COUNTY.

A. L. Stillwell, M. D., Reporter.

The annual meeting of the Somerset County Medical Society was held at the Ten Eyck House, Somerville, April 11. There was an unusually large attendance. Dr. A. Ernest Gallant, of New

York, gave an entertaining and instructive talk on "The Long Waisted Woman and Her Movable Kidney." Dr. Gallant illustrated his lecture with numerous charts, and gave many practical suggestions. Dr. Clark, of Trenton, Counsellor for this district, was present.

The following officers were elected for the ensuing year:—President, J. Harvey Buchanan; Vice-President, Henry V. Davis; Secretary, Wm. H. Long, Jr.; Treasurer, Thomas H. Flynn; Reporter, A. L. Stillwell; Censor, Peter J. Zeglio; Delegate to the State Society, John F. McWilliams. Drs. C. F. Halsted and Elizabeth R. Graff were elected to membership.

After the transaction of routine business the annua banquet was served by Landlord Lake.

Correspondence.

COMMITTEE ON LEGISLATION.

WILLIAMSTOWN, N. J., April 23, 1907.

DR. DAVID C. ENGLISH,

Editor of the Journal of the Medical Society of New Jersey, New Brunswick, N. J.

My Dear Doctor:—Thinking it might be of interest to the medical profession throughout the State, and as the Committee on Legislation made an urgent appeal to them for better work and more thorough organization of the profession before the political campaign commenced next fall, we will attempt to give you a resume of what the committee has been able to accomplish during the session just closed. It will be well to go back for a moment to what we intended to accomplish last summer. The chairman of the committee had his representative call upon some of the members of the profession of every County Medical Society in the State, urging them to thoroughly organize to interview the several candidates for the Legislature as to their standing in regard to the Osteopath Bill, and to our proposed Legislative action in reference to either a Pure Food Bill or a bill to control the nostrum evil. While our representative urged as strongly as it was possible upon the County Societies the necessity of taking some steps at once along the lines suggested, we are sorry to say that it did not meet with a hearty response on the part of the medical men of the State that we had hoped for. A few counties did most excellent work; and we were able to determine the status of their members before the meeting of the Legislature. Quite a number of counties did not make any report, which left us entirely at sea in certain directions. After the organization of the Legislature, we made an attempt to find out the status of the two houses on measures that we were interested in. Our investigations made us feel comparatively safe as regards the Senate, but were unable to get any data of any importance as to what the house would do.

The Osteopaths introduced their bill which was very similar to the one introduced by them last year, but in the judgment of the committee, more vicious than the bill of 1906. The committee was called together, and decided that, following our instructions from the State Society, we would

use every endeavor to defeat the measure. Notwithstanding that we were informed that we must present a bill that would regulate the practice of Osteopathy, and granting them such privileges as we deemed best, as the Legislature was strongly inclined to recognize them, we followed closely our instructions and fought the measure until we were convinced that there was a strong possibility of their bill being reported unless we introduced a measure to counteract it. The committee was called together and after considerable discussion, we decided to have a bill introduced which gave the Osteopaths one member on the Board of Medical Examiners, registered those in practice as Osteopaths, and giving them the right to take the examination before the Board of Medical Examiners where they should complete a term of study equal to the present requirements of the Board. This bill was introduced into the Senate by the Honorable Joseph S. Frelinghuysen, who worked untiringly for its passage. It passed the Senate by a safe majority, but was held up in the House, and as your Committee has almost positive evidence that the bill was stolen by a prominent politician from Essex County who carried it in his pocket until after the Legislature adjourned. While we were able to prevent the passage of any Legislation recognizing the Osteopaths, we are certain that our task will be more difficult next year than this, and we must be fully prepared at the opening of the Legislature with a bill which will be satisfactory to the medical profession of the State. To control such vicious measures, we must in the first place be thoroughly organized. A special committee should be appointed by each county medical society to look after all measures in their county, and that committee should find out the standing of the proposed candidates for the Legislature, and inform them very frankly that if they are opposed to such measures as the medical profession of the State advocates, the medical men would be against their election. Your committee must have more definite reports, and more active work on the part of the profession at large if we are to accomplish anything in the future.

Too much praise cannot be given the Honorable Joseph Frelinghuysen, Senator from Somerset County, for his untiring devotion to our work during the entire session. To his persistent work must be given the credit largely for the defeat of the original bill as presented by the Osteopaths. He has always informed your committee that he was anxious and willing to do everything to uphold the high medical standard now established in the State of New Jersey.

We are glad to state that the Pure Food Bill passed both Houses, which partially controls the Nostrum evil, and will be a long step in advance.

We trust that every member of the Medical Society of New Jersey will take this thing at heart, and earnestly strive for the careful and systematic organization of the State. If this is done, the work of your Committee on Legislation will be very much lessened, and the members of the Legislature will be so impressed that they will be compelled to listen to our suggestions.

While somewhat broken in health, so much so that your chairman is compelled to take a much needed vacation, I trust that at the meeting of the Society in June, the members of every county will pledge themselves to renewed and active interest in this work.

Very sincerely yours,

L. M. HALSEY.

SAFEGUARDING THE PUBLIC HEALTH.

New York, April 10, 1907.

*Journal of the Medical Society of New Jersey.**Committee on Publication.*

Dear Sirs—At the suggestion of Mr. Hugh F. Fox, editor of the *New Jersey Review of Charities and Corrections*, I am sending you a brief notice of the first meeting of the incorporators and board of directors of the Public Health Defense League, believing that you may desire to bring the subject of the League and its work to the attention of your readers.

I am also sending, under separate cover, explanatory literature concerning the League, in order that you may have a clearer idea of the objects and methods of the organization. This printed matter represents a complete history of the movement from its inception, and covers details not mentioned in the enclosed notice.

In your April issue I see that you have given extensive notices to the lecture work of Dr. J. N. McCormack, of Kentucky, who represents the American Medical Association. It may interest you to know that he has actively interested himself in the work of the League. I remain, sincerely yours,

F. ELIZABETH CROWELL,
Assistant Secretary.

Public Health Defense League.

On November 15th, 1906, at the Hudson Theatre, in New York City, there was held a conference of delegates to devise ways and means to safeguard the public health in every phase. The formation of a national society was authorized, whose avowed objects were to be to work for a National Department of Health—for uniform laws affecting the public health—for the enforcement of such laws, for higher health ideals as a nation, and generally for the enlightenment of the people on these important subjects along rational and scientific lines. The widespread interest in the movement then inaugurated is best evidenced by the fact that the delegates to this conference came from every State in the Union, and that there were represented 150 religious, philanthropic, professional and public welfare societies.

As the first fruits of the conference, 2,000 applications for charter membership were presented to the incorporators of the Public Health Defense League, at their meeting held Tuesday evening, April 2d, at the Hotel Royalton, New York City. The meeting was organized and the charter for the National Society was presented and adopted. The election of officers resulted as follows: Austin G. Fox, President; Eugene O'Dunne, Baltimore, Secretary; Harry Arnold, assistant Secretary; Windsor Trust Company, Treasurer; J. F. Timmons, assistant Treasurer. At a meeting of the Board of Directors, which immediately followed, the appointment of the following committees was authorized—on Legislation, Extension, Official Publication, Publicity, Cooperation with other societies and kindred movements, and on a National Department of Health. The personnel of the Board of Directors is as follows: Dr. Frank Van Fleet, Dr. Silas Hallock, Albert M. Austin, Champe S. Andrews,

John S. Cooper, Austen G. Fox, Dr. Wendell C. Phillips, Dr. Floyd M. Crandall, Dr. Walter Lester Carr, Dr. Ernest J. Lederle, J. M. Rice, Dr. Henry S. Stearns, Dr. Livingston Farrand, Herbert C. Lakin, A. E. Goodridge, Rev. J. J. Wynne, Dr. William M. Polk, O. E. Edwards, Gaylord S. White, Rev. Thomas R. Slicer, Dr. Thomas Darlington, Harry Arnold, all of New York City; Irving J. Fisher, Yale University, New Haven, Conn.; Dr. William L. Browning, Brooklyn, N. Y.; W. F. C. Tichborne, Mount Vernon, N. Y.; Howard J. Rogers, Albany, N. Y.; Harold P. Brown, Montclair, N. J.; Eugene O'Dunne, Baltimore, Md.; Robert E. Belcher, Boston, Mass.; Dr. Henry W. Cattell, Philadelphia, Pa.

In order to carry out efficiently the program to which the League is definitely committed, it will be necessary to have a tremendous popular membership and a large annual income devoted to the scientific study of those conditions which make for and against the public health and to secure unity of action among all those forces that are endeavoring to conserve the public health along certain lines. The work of extension is being rapidly carried forward and it is hoped that before long State branches of the League will be formed in every State in the Union. Already the work of organization is practically completed in Maryland, Massachusetts, Pennsylvania and New York State, and gratifying responses to appeals for membership are being received from New Jersey, Ohio, Illinois and several other States. The offices of the League, both National and for New York State, will be in the United Charities Building. Any one desiring information concerning the League may write to the Secretary, United Charities Building, 105 East Twenty-second street, New York City.

NATIONAL TUBERCULOSIS ASSOCIATION.

The third annual meeting of the National Association for the Study and Prevention of Tuberculosis will be held at the New Willard Hotel, Washington, D. C., May 6 to 8, 1907, opening at 11.30 A. M. on the 6th with an address by the President, Dr. Herman M. Biggs, of New York City. The Secretary is Mr. Livingston Farrand, New York City; he will speak on "The Campaign Against Tuberculosis in the United States." There are five sections: Sociological, Clinical and Climatological, Pathological and Bacteriological, Surgical and on Tuberculosis in Children. Several papers and addresses by eminent practitioners from different sections of the United States will be presented before the various sections. Dr. Schmeiden, of Bonn, Germany, will read a paper on "The Treatment of Bone and Joint Tuberculosis by 'Stauung's-Hyperemie'."

The New Jersey Orthopaedic Hospital and Dispensary, established at Orange three years ago, has for its sole object the care of cases suffering from crippling and deforming diseases. The annual report for 1906 shows the rapid advancement of this worthy charity. It is desired that the profession of New Jersey shall cooperate in this charitable work. Dr. Robert E. Soule, of New York, is surgeon in chief of the institution.

THE JOURNAL

OF THE

Medical Society of New Jersey.

MAY, 1907.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any one failing to get the paper promptly will confer a favor upon the Publication Committee by notifying them of the fact.

All communications relating to the JOURNAL should be addressed to the Committee on Publication, 95 Essex Avenue, Orange, N. J.

IMPORTANT NOTICE.

The attention of the Secretaries of the various County Medical Societies is called to the great importance of sending their reports promptly to Dr. W. J. Chandler, Secretary of the Medical Society of New Jersey, as required by the By-laws of the Society. The Treasurers of the County Societies should also send their reports with the amount of dues (\$2 per member) to Dr. Archibald Mercer, Treasurer of the State Society, before May 25, 1907. The two following items indicate some important points which should be observed in preparing these reports:

Before the next JOURNAL is issued the annual meetings of the various County Medical Societies will have been held. It is important that the County Secretaries remember to send to the State Secretary their four separate reports *on or before May 25th, 1907*. Special attention should be given to the orthography of proper names. Where possible the *full* name should be given with the post office address. In the admission of new members the blanks for permanent record should be filled out and sent to the State Secretary (from whom these blanks can be obtained) so that a complete record may be on file.

When suspended (or dropped) members are reinstated in a component society their dues for the *current* year, together with their *names*, should be sent to the State Treasurer promptly in order that their names may be added to the list. Often the dues are sent but without names so that the State Treasurer is ignorant of what names to add. Consequently such reinstated members do not receive the JOURNAL nor can they be certified to the A. M. A. as being in "good standing."

THE OSTEOPATHIC BILL DEFEATED.

After the hardest fought series of battles ever engaged in by the medical men of New Jersey, the osteopaths have again met with defeat. To the Committee on Legislation with the hearty coöperation of a few other prominent physicians of our State, is largely due the victory, and the people of New Jersey are to be congratulated not only on the outcome, as it has safeguarded the health interests of our State, but also that the Medical Society of New Jersey has again proven itself true to the traditions of the past in maintaining and advancing the high standard of medical education, insisting upon the principle that the educational qualification shall be the basis for medical licensure, and that the excellent work of our State Board of Medical Examiners in that direction, and of our State Board of Health in the prevention of contagious and infectious diseases shall not be jeopardized or nullified.

The contest before our Legislature this year was a strenuous one—seemingly a life or death struggle on the part of the osteopaths, who, led by a shrewd lawyer of some influence, had been industriously working for months, flooding the legislators with letters from scores of citizens urging their votes for the osteopathic bill for a separate board of examiners, buttonholing the legislators day after day when in session, and by misrepresenting our attitude and with specious argument seeking to overcome at the several hearings granted by the Senate and Assembly Committees, the strong arguments in behalf of the people's interests. One of the greatest difficulties encountered—which has always marked the physicians' efforts for the protection of the health interest of the State—was to make the ordinary politician recognize the possibility of unselfish, disinterested service for the public good. He is so accustomed to argue "how will my vote affect me; will it advance my political fortunes," and so the false cries of persecution and the doctors fighting for their own pecuniary interests

deceive them or give them excuse for voting against the right.

The legislator who acts intelligently upon his conscientious convictions is open to real argument, and false cries and specious arguments will have little effect upon him. He will see that our action is not mercenary, and is really against our profession's pecuniary emolument. This is the class of legislators to whom we mainly appealed, and, to the credit of our State be it said, that they were in the majority in the Senate, the only body in which the bill came to a vote; we hope it would have been the same in the Assembly. Recalling Dr. Halsey's paper in our April issue, on "The Medical Man in Politics for the Public Good," we hope our physicians throughout the State will act upon his suggestions in using their influence for the election of such legislators, knowing that our appeals in all such cases will receive the respectful consideration which their importance demands and will prove weighty, if not decisive, in shaping legislation for the benefit of New Jersey's health conditions.

We were surprised to hear one prominent legislator, serving on one of the committees before whom our committee appeared, say: "I propose in this, as in other matters, to vote for what the people of New Jersey want." Is that a proper conception of a legislator's duty and responsibility? If he had said what the people of New Jersey need, what their proper protection requires, we should not take issue with him. But did the honorable gentleman vote in favor of the local option bill, which would give the people a chance to say what they wanted in reference to that measure of protection? Did he know what the people wanted concerning this osteopathic bill? Was he to decide? If so, he had 4,000 physicians in New Jersey—regulars, homeopaths, and eclectics—who for the public good were opposed to the osteopaths' bill, and 100 osteopaths who were "moving heaven and earth" or some other region, in *behalf of their own interests*. True, they

had flooded the legislators with letters soliciting votes for their bill. The politicians know how easy it is to get such letters and how many of "the people" they truly represent. Our committee could have done the same; but they would not—they appealed directly to the intelligence of our legislators who ought to recognize the fact that in all matters medical, affecting the health and lives of our citizens, the physicians are best qualified to judge, and their judgment should be decisive, provided they are not governed by selfish consideration, for their own pecuniary advantage in advocating or opposing any particular measure. It seemed an insult to the intelligence of our legislators to believe them capable of attributing to the medical profession (all schools united) any motive in opposing the bill of the osteopaths other than the protection of the highest, most sacred interests of the citizens of our State, especially when in *our* bill, as presented by Senator Frelinghuysen (which will be found in another column), we made every fair concession and stood firmly only for the one vital principle that THE EDUCATIONAL QUALIFICATION SHALL BE THE BASIS FOR MEDICAL LICENSURE. We feel perfectly sure in stating that the Medical Society of New Jersey will never consent to yield that principle, and equally sure that the people of New Jersey who understand its full import will never "want" it yielded.

Senate Bill No. 302, introduced by Senator Frelinghuysen, which largely eliminated the dangerous features of the osteopaths' Assembly Bill No. 469, passed the Senate, but was not reported in the Assembly. A communication just received from Dr. Halsey, chairman of our committee (which will be found on another page), in reporting on the committee's work, explains the final outcome of this year's bill. We therefore forbear further comment except to urge our members to become more thoroughly acquainted with the real issues involved and be prepared for future contests. We have far more than enough now of incompetent men entrusted with the care of human life and the treatment of its ills;

the adoption of Assembly bill No. 469, which the osteopaths tried to force through, would have largely increased the number, and their last so-called compromise bill was not much better. We cite one feature of the latter, which in these days of great scientific medical progress ought to stir every practitioner—even those of limited scientific attainment—to action for the defeat of this unscientific system of practice. The bill provides that the osteopaths shall not give, prescribe or use drugs or medicines, or perform surgery with the knife, and yet gives them power to treat all diseases—even contagious and infectious diseases by osteopathic methods, and they claim they are competent to treat, and will so treat, all diseases. Just think of it! Treat such diseases as diphtheria (without antitoxin), scarlet fever, pneumonia and syphilis without medicines; peritonitis and ectopic gestation with rupture without the knife, and practice midwifery without the use of ergot, chloroform or instruments! It is absurd! Would it not be criminality authorized and justified by legal enactment?

AMERICAN MEDICAL ASSOCIATION.

Our members will remember that the American Medical Association honors New Jersey again this year in holding its annual meeting in Atlantic City June 4-7. The annual session will be opened by the retiring president, Dr. William J. Mays, of Rochester, Minn., after which the president-elect, Dr. Joseph D. Bryant, of New York City, will be inducted into office. Excellent programs for the various sections have been completed and the meeting promises to be one of unusual interest, with even larger attendance than that of three years ago at the same place. Dr. W. Blair Stewart is chairman of the local committee of arrangements.

We are pleased to add to the list of Life Insurance Companies which recognize the fact that it is poor economy to employ cheap medical examiners, the Connecticut Mutual Life Insurance Company. They will pay the moderate, but satisfactory, fee of five dollars for every examination.

OUR 141ST ANNUAL MEETING.

In another column of this issue of the JOURNAL will be found the Preliminary Program of our annual meeting to be held at Cape May June 25-27. Our Committee on Scientific Work has certainly provided an excellent program, which ought to insure a large attendance of the members of our county societies. Fuller announcements will be made in the June issue of the JOURNAL.

We announce with great pleasure and satisfaction that the Pure Food Bill passed both Houses of our Legislature. Our representatives are worthy of commendation in thus protecting and conserving the health interests of our State and our citizens are to be congratulated not only in this advance step for the prevention of the adulteration of food, but also of medicines and the great help it will afford in controlling the *Nos-trum Evil*.

We regret that the reports of the Essex and Middlesex County Societies, with an excellent paper by Dr. E. J. Ill, on "The Treatment of Albuminuria in Pregnancy," came too late for insertion in this issue of the JOURNAL. They will appear in the June number. We also have the promise of the valuable paper read by Dr. L. Duncan Bulkley, of New York City, at the annual meeting of the Middlesex County Society, on "Some Practical Points in the Diagnosis and Treatment of Skin Diseases." The Reporters of the County Societies are requested to send to the editor the full names of all new members elected and their residences before May 24th.

The annual meeting of the New Jersey Association for the Prevention and Relief of Tuberculosis will be held in Newark May 15, 1907, when officers will be elected for the ensuing year. The report of the executive secretary, Mr. William C. Smallwood, we know, from a general outline of it which it has been our privilege to examine, will show a year's work of remarkable activity and large outcome. We will give an abstract of it in our June issue of the JOURNAL.

We recognize the relations existing between the medical profession and that of the manufacturing chemist—not perhaps as close as those relations should be, but we do commend those firms which are noted for their strict business integrity and their care in maintaining a good reputation for the purity of their preparations, and we are not indifferent to their losses. We especially commend the case of the well-known firm of Parke, Davis & Co., which has just suffered severe loss in the death of their President, Theodore D. Buhl. The action of that company on his death speaks in fitting terms of his integrity, fidelity, sound judgment and deep sense of the firm's obligations as purveyors to the medical profession and to suffering humanity. We extend our sympathy to the firm in the great loss they have sustained.

PRELIMINARY PROGRAM OF THE 141st. ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY.

At Cape May, June 25-27, 1907.

TUESDAY, JUNE 25, 1907, 4 O'CLOCK, P. M.
Some Remarks on the Lymphatics, by Dr. Dr. E. Zeh Hawkes, Newark.

Discussion.

Otitic Pyaemia Without Mastoid Involvement, by Dr. W. P. Eagleton, Newark.

Discussion.

The Legality of State Medical Examinations and Reciprocity in Medical Licensure, by Dr. E. B. B. Godfrey, Camden.

Discussion.

EVENING SESSION, 8 P. M.

Oration in Surgery, Dr. A. Vander Veer, Albany, N. Y.

Oration in Medicine, Dr. Morris Manges, New York City.

When and When Not to Operate in Ruptured Ectopic Pregnancy, by Dr. J. S. Baer, Camden.

Discussion.

WEDNESDAY, 10 A. M.

Detached Placenta, Dr. J. W. Martindale, Camden.

Discussion.

Symposium on Diseases of the Gall Bladder:

1. Etiology and Pathology, Dr. H. G. Norton, Trenton;
2. Diagnosis, Dr. P. A. Harris, Paterson;
3. Complications, Dr. G. K. Dickinson, Jersey City;

4. Medical Treatment, Dr. J. H. Musser, Philadelphia;

5. Surgical Treatment, Dr. Wm. Rodman, Philadelphia;

Discussion opened by Dr. E. W. Hedges, Plainfield.

AFTERNOON SESSION, 3 P. M.

Address of the President, Dr. Alex. Marcy, Jr.

Address of the Third Vice-President, Dr. B. A. Waddington.

How Far may the General Practitioner Employ and Benefit from Laboratory Methods of Diagnosis? Dr. Robert N. Wilson, Philadelphia.

Physical Education: Its Needs and Development, Dr. G. O. Brewster, Grantwood; Dr. Daniel Strock, Camden.

THURSDAY, 9 A. M.

Myasthenia Gravis, Dr. C. L. Lindley, Lakewood.

Discussion.

Symposium on the Eruptive Diseases:

1. Scarlet Fever, Dr. Hiram Williams, Passaic;

2. Measles, Dr. Philip Marvel, Atlantic City;

3. Roethlin, Dr. Alexander McAllister, Camden;

4. Smallpox, Dr. E. E. Worl, Newark;

Discussion.

Also a paper (subject announced later), by Dr. A. J. Walschied, Union, Hudson County.

The Reporters of the County Societies are urgently requested to send their report to Dr. Norton L. Wilson, Chairman of the Committee on Scientific Work, Elizabeth, N. J., before May 25th.

NEW OSTEOPATHIC BILL, NO. 302.

**Introduced by Senator Frelinghuysen and
Passed by the Senate.**

A FURTHER SUPPLEMENT to an act, entitled "An act to regulate the practice of medicine and surgery, to license physicians and surgeons and to punish persons violating the provisions thereof," approved May twenty-second, one thousand eight hundred and ninety-four.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. The State Board of Medical Examiners shall hereafter consist of ten members, instead of nine, as heretofore. Such additional member shall be appointed by the Governor, by and with the advice and consent of the Senate, and shall be an osteopath, residing in this State, of recognized professional ability and honor; the term of his office shall be three years and until his successor is appointed, and he shall be entitled to the same

rights and subject to the same duties as any other member of said board.

2. All applicants for license to practice osteopathy in this State shall be examined by said osteopathic member of said board in those subjects which are alone peculiar to that school of practice, but in all other respects every such applicant shall be subjected to the same rules, regulations and examination to which applicants for license from other schools of practice are in common subjected.

3. Any person engaged in the practice of osteopathy in this State prior to the passage of this act shall, within sixty days, make application to said State Board of Medical Examiners for a license to practice, and shall exhibit to said board a diploma issued by a legally-incorporated school or college of osteopathy recognized by said board, shall thereupon receive from said board its license granting him or her the right to practice osteopathy in this State; *provided*, that such applicant shall make proof to the satisfaction of said board that he or she is the person to whom said diploma was issued, and that he or she was engaged in the practice of osteopathy in this State prior to the passage of this act and was and at that time had been a legal resident of this State for a period of one year; but said license shall not permit nor be construed to authorize any such person to prescribe, administer or give any drug or medicine, practice surgery or to sign any birth or death certificate.

4. No person shall commence the practice of osteopathy, nor shall any person licensed under the provisions of section three hereof prescribe, administer or give any drug or medicine, practice surgery or sign any birth or death certificate in the State of New Jersey after the passage of this act until after he or she shall have been regularly examined and licensed to practice medicine or surgery by said Board of Medical Examiners as provided in this act and in the act to which this act is a further supplement.

5. All acts and parts of acts inconsistent with the provisions of this act are, so far as inconsistent therewith, hereby repealed, and this act shall take effect immediately.

AMERICAN ANTI-TUBERCULOSIS LEAGUE.

The annual meeting of the American Anti-Tuberculosis League will be held at Atlantic City, N. J., June 1-4, 1907. The circular states that this League was "Organized for the prevention of consumption. To educate the people that this is a preventable disease. To secure State aid for poor consumptives. To establish hospitals in every State in the Union." The headquarters will be at the Hotel Holmhurst, South Pennsylvania avenue. Dr. Edward Guion, Atlantic City, is chairman of the Committee of Arrangements, and several prominent physicians of New Jersey hold official positions in the League. A woman's auxiliary is being formed, of which Mrs. J. R. Briggs, of Dallas, Tex., is the leader.

Counter Prescriber Prosecuted.—The first arrest under the New Jersey law providing against the prescribing for sick persons by druggists was made last week in Bayonne, the city physician, acting in behalf of the health board, being the complainant. The offending druggist pleaded ignorance of the law and was dismissed with a reprimand.

Current Medical Literature.

The Relation of Diseases of the Nasal Accessory Sinuses to Diseases of the Eyes.

—Brawley remarks that the treatment of iridocyclitis is operative. The middle turbinal should be cocaineized and a notch made at the point of its anterior insertion into the lateral nasal wall, a Myles punch being used. The free end of a wire loop on a Krause snare is now introduced into the notch, where it is held firmly while the canula of the snare is pushed along the under surface of the middle turbinal as far as is considered necessary. Closing the snare gives a clean cut, smooth-edged wound, which rapidly heals. In case the turbinal is not large, much useful tissue may be saved by merely punching out a portion along its line of insertion, thus uncovering the hiatus. As a rule, probing and irrigation are unnecessary, and when carried out always leave room for doubt as to the part they play in producing the mucopus occasionally found.—*N. Y. Med. Jour.*, Mar. 30, '07.

Empyema of Some of the Accessory Sinuses of the Nose Complicated by an Orbital Abscess.

—J. Guttman's patient was a girl of fifteen years, whose initial symptom was toothache followed by a swollen jaw. Later the swelling extended to the eyelid and the author was called to see the girl. Pus was found in the antrum. A radical operation was done on the antrum, the middle turbinal removed in front, and the ethmoidal sinus entered. Pus escaped from the latter cavity. Before the operation there were evidences of an orbital abscess. The latter was opened through the inner canthus and the communication between the orbital abscess cavity and the ethmoidal sinus enlarged by breaking through the lamina papyracea, which had already been partially destroyed by the suppurative process. The whole process of infection was very short, only forty-eight hours having elapsed from the beginning of the toothache to the swelling of the eyelids. It is not improbable that the primary cause of the onset of the disease is to be found in an inflammation at the root of the tooth, which spread to the maxillary sinus, from there to the ethmoidal sinus, and thence to the orbital cavity.—*N. Y. Med. Jour.*, Jan. 26, 1907.

Some of the Lesions of the Middle Ear Due to Influenza.

—Dr. Gorham Bacon, New York Academy of Medicine, February 7, 1907, said that at the New York Eye and Ear Infirmary there had been, in 1897, 161 mastoid operations; in 1880 the number had rapidly increased, while in 1905 there had been 555 operations. Influenza played an important part in the acute inflammations of the middle ear, and children were more frequently affected than adults. The pain was slight even in the severer cases. The sticky sanguinolent purulent discharge was quite characteristic in children, and in examining the pus or serum, one found usually a mixed infection. The staphylococcus might be the cause of the severe inflammation. After incising the drum membrane the temperature usually fell, the discharge became purulent, and the disease ran a course of from ten days to three weeks, the temperature ranging from 101° to 105°. It was in this class of cases that the otologist should exercise great care, and if a simple bronchitis was present, it was not wise to administer an anes-

thetic for fear of setting up a pneumonia. Incise the drum membrane without a general anesthetic; but if it was absolutely necessary to use one, he advised chloroform. After incising the drum head the high temperature might be due to mastoid involvement, or to a deep-seated pneumonia. The knowledge of the exact nature of the infection he considered important. The mastoid involvement or infection might be different type on either side. In cases of sinus thrombosis, Dr. Bacon said he had seen a case in which the temperature remained high. Since the influenza otitis was apt to be of a severe type, it was wise to make an early incision in the drum membrane, even if there was but little bulging. It was a difficult matter to formulate exact rules for one's guidance for operating in cases of otitis following grippé; but, as a rule, it should be performed early if the temperature remained up. Examinations of the blood should be frequently made to see if there was a leucocytosis or not. In some cases a mastoid operation could be avoided by making incisions into the drum membrane. After mastoiditis, septic thrombosis and sigmoid disease were the most frequently met complications. Attention should be directed to thrombosis of the jugular bulb in children as well.—*N. Y. Med. Record*, March 2, 1907.

The Indications for and the Technique of Paracentesis of the Drum Membrane.

—Dr. John C. McCoy read this paper at the New York Academy of Medicine March 14, 1907. He first took up the anatomical considerations, believing that for the intelligent understanding of the causes and effects of suppuration of the middle ear, it was absolutely essential to have a comprehensive knowledge of the anatomy of this region. It was of special interest to note that the roof or vault of the tympanic or middle ear cavity was formed by the osseous lamina of the squama and had lying about it a portion of the brain of the middle fossa. In infants the petrosquamous suture was still patent, and there was an intimate relation of the blood vessels of the dura and of the middle ear. This explained why so many infants manifested meningeal symptoms when they had a suppuration in the middle ear, and why it was so easy for them to develop a meningitis. The following points should be looked for in a normal drum: (1) A lustrous pearl-gray, slightly concave, membrane. (2) A bright reflex of light at the anterior inferior quadrant of this membrane. (3) A prominent white projection about the size of a small pin head situated in the center of the upper portion of the drum. (4) Two whitish bands running from this prominent white spot in a horizontal direction, one to the anterior circumference, and the other to the posterior circumference of the drum. These were known as the anterior and posterior folds, and marked the dividing line between the relaxed and the tense portion of the drum. Aside from traumatic rupture of the drum and infection of the middle ear from the external auditory canal, the cause which led in the great majority of cases to a suppurative inflammation of the middle ear cavity, was an extension of an inflammation from the nose or pharynx through the Eustachian tube. Occasionally, however, the inflammation in the middle ear was primary. It had been demonstrated that streptococci were found in the healthy middle ear free from all inflammation. The diseased conditions, which conducted to an involvement of the middle ear through the Eustachian tube were such as occurred in any of the exanth-

mata, especially scarlet fever, diphtheria, measles, pneumonia and influenza. It frequently followed the ordinary catarrhal cold, and it might follow the introduction of fluids through the nose into the Eustachian tube. Following the changes to be seen in the drum membrane from the inception of the inflammatory process to the time when it became necessary to incise it, there would be seen, first, that the drum was losing its luster; following this there would take place a congestion in the upper relaxed portion of the drum which would gradually spread over the whole drum. Then would be noticed a slight bulging of outward, usually in the upper posterior portion of the drum. It was then time to incise it. In examining an ear for this condition it was well to bear several points in mind, as follows: (1) In infants, the auricle should be drawn downward and backward to separate the inferior from the superior wall of the meatus. In older children the auricle should be drawn upward and backward. (2) One should be prepared with an applicator and cotton to remove particles either of wax or dead epithelium or medicaments, such as oil or other substances that might have been introduced into the canal. (3) One should remember that instead of seeing a red bulging drum, one might see a drum of a dull whitish-gray color. This was due to necrosis of the epithelium of the dermal layer of the drum, and if this was gently swabbed it would come away and reveal the congested drum beneath. (4) It was always well to examine both ears. Many children gave no subjective symptoms of ear trouble. Earache was frequently produced by decayed teeth, without any change in the ear whatsoever. Fever was really the only constant symptom, and in the absence of all other physical signs to explain it, the ears should always be examined. Prior to a paracentesis the external auditory canal should be sterilized by irrigation with 1-2000 bichloride solution. The hands should be sterilized and the instruments boiled. In infants it was better not to give an anesthetic. For older children nitrous oxid gas was safe and efficient. Beginning at the lower posterior segment, a small, straight or sickle-shaped knife should be plunged into the membrane, and this should be carried directly up to the superior margin of the drum and in withdrawing the incision should be carried outward for about one-eighth of an inch. This gave free drainage to the whole cavity; the loss of blood and fluid relieved the pressure and pain; there was more rapid healing of the cut surface than if a small opening was made or a spontaneous perforation was allowed to take place; there were also minimized the chances of mastoid involvement. The dangers of paracentesis were that if too much force was used, or if the operator did not know the direction in which his knife was cutting, he might enter some of the structures he had enumerated; cases had been reported where the jugular bulb, the carotid artery, or the internal ear had been entered.—*N. Y. Medical Record*, April 13, 1907.

Nervous Lesions Accompanying Exophthalmic Goiter.—Poggio describes the autopsy on a woman of twenty-eight years, suffering from exophthalmic goiter, who died in coma. Except for slight cardiac hypertrophy the organs were normal. The central nervous system was congested and in the medulla, pons, the floor of the fourth ventricle and in the nuclei of several of the cranial nerves there were degenerative changes.—*Clinica Medica Italiana*.

The Physiological Action of Alcohol.

—W. S. Hall, in the February 2, 1907, *Journal A. M. A.*, discusses the relation of alcohol to living protoplasm, pointing out that it is a normal product of metabolism of the yeast fungus; that it belongs to the class of substances that are completely metabolized and is passed out because its existence is destructive to the living cell; in short, that it is an excretion toxic to the organism that produces it. An excretion of this type is also toxic to higher organisms, and this is the case with alcohol. Admitting that it is oxidized in the liver and produces heat and that it may lead to decrease in the catabolism of carbonaceous foods, the heat produced is not a normal catabolism, but is simply the result of a protective oxidation, which is insufficient, the toxic action showing in its narcotic effects. The decreased catabolism of carbonaceous and nitrogenous foods following the ingestion of a narcotic is a universal fact depending on the drug effect and giving to the oxidized narcotic no significance as a food. It may be said, he says, without reservation that ethyl alcohol is not a food in the scientific significance of the word.

Alcohol in Its Relation to Degeneracy.

—E. S. Talbot, in *Journal A. M. A.*, February 2, 1907, holds that alcoholism is often the expression of an existing degenerative taint rather than its causal factor, and that ignoring all but the alcoholic factor in degeneracy is often the source of error. He points out that the effect of alcohol on the individual is much like that of the chronic contagions, but with a greater deteriorating action on the nervous system, and that in its degeneracy-producing action it is aided by poverty and other bad environmental conditions. The routine prescription of alcohol for various ailments is undoubtedly responsible for much inherited degeneracy, and this way an immense amount of harm is done by alcoholic nostrums. The precursor of degeneracy is a neurasthenia induced by alcohol in these cases, and the neurasthenia of the ancestor becomes the neurosis of the descendant.—*N. Y. Med. Record*, Feb. 9, '07.

A Case of Cervical Rib, with Symptoms.

—Dr. Lewis A. Conner presented before the *Practitioners' Society of New York*, March 1, 1907, a girl, seventeen years old, with bilateral cervical ribs, who had been shown to the society one year ago. At that time she complained of occasional slight pains in her left shoulder, but it was impossible to tell whether or not the pains were related to her supernumerary rib. Since that time the pain had become more constant and severe, and now was present most of the time. It no longer was felt only in the shoulder, but frequently radiated to the elbow. There was no evidence of muscular atrophy on the affected side, and the left deltoid showed only slight diminution in faradic irritability. Power in the two arms was equal, but the left tired more easily. The skin sensibility was not disturbed. In the light of the developments of the past year there was now little doubt that the symptoms were the result of pressure of the cervical rib upon the nerve trunks, and if these symptoms increased the question of operation would have to be considered. In reply to a question, Dr. Conner said this condition of cervical rib was frequently bilateral, but not always. The operation for the removal of the rib was regarded by surgeons as sometimes quite a difficult one. The symptoms

associated with the condition were apt to develop during early adult life, which was perhaps due to the elongation or increasing rigidity of the ribs at that time.—*N. Y. Med. Record*, April 13, 1907.

Operations During Typhoid Fever.

—At a recent meeting of the Liverpool Medical Institution (*Lancet*, January 12, 1907), Dr. W. T. Thomas reported two cases of operations during typhoid fever, one for perforation, the other for appendicitis, in both of which recovery took place. He called attention to the fatal character of perforation unless surgically treated, when the recovery rate was 30 per cent. or more. Although in many cases the diagnosis was uncertain, it would be wiser to explore (under local anesthesia) than to wait until general septic peritonitis had set in. The treatment of the perforation by quick suture or the formation of a fecal fistula appeared to be the two alternatives—fancy work such as enterectomy with end-to-end anastomosis was not to be recommended; enterostomy had the further advantage of draining the typhoid intestine and keeping it at rest. Dr. F. T. Paul referred to a case in which a perforation twelve inches from the cecum occurred three months after the onset of typhoid fever. In this case the ulceration was so extensive that the perforation could be closed only by excising it and the patient died nine days after the operation. Dr. T. C. Jones mentioned a case in which he had operated successfully last July. A Lascar boy was taken to the Liverpool Infirmary at the end of the second day after perforation of a typhoid ulcer. Simple suture of the ulcer was performed and the abdomen was cleaned of intestinal contents. The boy was transferred to his ship three weeks afterwards. Perforation was rare in Hindus and the infection was comparatively slight. Dr. R. W. Murray said that better results from operative interference would probably be obtained if, as a general rule, the bowel at the point of perforation was brought to the surface and a fecal fistula temporarily established. Such an operation could be quickly performed and would have the great advantage of permitting the inflamed bowel to rest.—*N. Y. Med. Record*, April 13, 1907.

Infective Throat Conditions.

—Young calls attention to distinctive features of such conditions. Simple scarlatinal throat with its vivid red, its dysphagia and absence of invasion of the larynx is usually unmistakable. One must exclude tonsillitis, measles, smallpox, diphtheria and syphilis. In septic tonsillitis there is sudden onset, no vomiting, febrile pulse and temperature, and an erythematous rash, if any. Follicular tonsillitis differs from diphtheria in that the patches are mucoid and easily removed, but quickly reappear. The mucosa is bright red, while the exudate has no distinct edge such as is present in diphtheria. A patient with diphtheria is described as prostrate, pallid, pulseless, placid, painless, with putrid breath, and temperature about 102° Fahr. Syphilis has a throat which is dusky red and injected with circular tonsillar ulcers; symmetrical erythema with mucus plaques on the soft palate and fauces all characteristic. Faucial erysipelas may often be diagnosed by its oedema. A septic sore throat which is due to infected milk, with general septic symptoms, is now occasionally seen. Other conditions mentioned are acute pneumococcal throat inflammation, streptococcal inflammation of the fauces, and a sore throat caused by the inhalation of sewer gas.—*The Practitioner*, March.

Physical Methods of Treating Heart Disease—

Bennett insists that in dealing with heart disease a preference should be given for solid food, as long as possible, since it occupies less space in proportion to its nourishing properties, while its presence favors peristaltic action and therefore circulation. The Salisbury steak, when carefully prepared, is greatly to be commended, as also cheese, peas, beans and lentils. Green vegetables can not be used exclusively as a diet. The carbohydrates must be selected with the following points in view: (1) Their liability to promote fermentation. (2) The patient with heart disease is not usually fed with the view of obtaining material for muscular exertion. (3) If muscular energy rather than muscular tissue is required, meat and other proteids may be substituted for carbohydrates. Thorough cooking of starchy foods is essential. If liquid food is preferable in a given case, soups and milk will supply the requirements. The indigestion so common in cardiac disease can often be relieved by lessening the quantity of fluid ingested. The tendency of a milk diet to cause constipation in some cases of cardiac disease must also not be overlooked. Eggs should be eaten raw or only slightly boiled. Tea and coffee are recommended. Alcohol should be used in great moderation if at all, it is better to hold it in reserve for emergencies. Salines and green vegetables will often prove healthful adjuncts of diet.—*The Practitioner*, March, 1907.

Goiter, the Surgical Treatment of.—

C. H. Mayo, M. D., *Journal of the A. M. A.*, January 26, 1907, reporting three hundred operations on the thyroid, says that he prefers the collar or transverse incision. In tumors of medium size this crosses the center of the tumor, in larger tumors it crosses the upper third and the lower flap is split vertically to the sternum if necessary.

The incision is through the skin and platysma muscle, the flap being raised to expose freely the muscles covering the gland, namely, the sternohyoid, the inner portions of the sternomastoid and omohyoid. In medium-sized growths muscle separation will permit of the delivery of the tumor. The muscle section of the sternohyoid and thyroid group, if made, should be near their upper attachment so as not to interfere with their nerve supply and also to break the line of scar formation from that part of the skin. After the removal of the gland, the severed muscles are carefully united by suture. The upper section also permits of early ligation of the superior thyroid which is the key to the situation.

Should there be a large area of cut gland exposed it is burned over with carbolic acid, followed by alcohol, or often Harrington's No. 9 solution is applied over the cut tissues to close the lymph absorbents and favor drainage. If there has been but little traumatism drainage is not employed. Large incisions and large cavities are drained temporarily. All exophthalmic cases are drained as freely as the most septic wound.

These cases absorb some wound secretion containing colloid, causing rise in temperature and increase of pulse the next day. To delay absorption, especially in exophthalmic goiter, patients are given large quantities of salines by the bowel directly after the operation and for the first two to four days. If not retained by the bowel, they are given by subcutaneous administration.

The wound is closed by subcuticular suture, great pains being taken to unite the platysma to prevent spreading of the scar.

Personal.

Dr. E. L. B. Godfrey, of Camden, has returned from the Pacific Coast, with health restored and has resumed practise.

Dr. Horace G. Norton, of Trenton, recently appointed a member of the State Board of Medical Examiners was graduated from Peddie Institute in 1878, and from the University of Pennsylvania in 1880. Dr. Norton is a member of the staff of St. Francis Hospital, Trenton, and holds membership in the Mercer County Medical Society (of which he was formerly president), the State Medical Society, the American Medical Association, the Trenton Board of Trade, the Trenton Natural History Society and the Sons of the Revolution.

Deaths.

MILLS—In Newark, N. J., April 21, 1907, Andrew M. Mills, M. D., aged 36. He was the son of Dr. Andrew M. Mills, who died in Newark in 1891. He graduated from the New York University Medical College in 1892 and settled in Newark; was elected County Physician in February last; soon after became ill and, on urgent advice of friends, took a trip for his health. He was for several years one of the visiting physicians of the Newark Eye and Ear Infirmary; was a member of the staff of St. Michael's Hospital; a member of the Physicians' Club of Newark; of the Practitioners' Club, and of the Essex County Medical Society.

O'SHEA—In Paterson, N. J., February 20, 1907, Joseph O'Shea, M. D., aged 33. He graduated from the Bellevue Hospital Medical College in 1896. He had been for four years medical school inspector.

ROGERS—In Trenton, N. J., April 11, 1907, suddenly, from angina pectoris, Elmer H. Rogers, M. D., aged 47. He graduated from the Jefferson Medical College, Philadelphia, 1885; subsequently took post-graduate courses in Berlin, Germany, at the Metropolitan College of London and the Polyclinic Laboratories of the Medical Graduates College of London, England. He was a member of the American Medical Association, the Medical Society of New Jersey, the Mercer County Medical Society, the Trenton Medical Library Association, the Brotherhood of America, the Junior O. U. A. M., Sons of St. George and other organizations.

SKILLMAN—In Princeton, N. J., March 6, 1907, Thomas A. Skillman, M. D., aged 59. He graduated from the New York University Medical College in 1878 and settled in practice at Dutch Neck, Mercer County. Subsequently he practised for brief periods in Quakertown, Stanton and Harlingen, and later for several years in New Brunswick, N. J.

WEIGAND—In Jersey City, N. J., March 23, 1907, after four months' illness with tuberculosis, Otto Albert Weigand, M. D., aged 38. He graduated from the College of Physicians and Surgeons (Columbia), 1890; was a member of the Hudson County Medical Society, and of the American Medical Association.

YOUNG—In Bordentown, N. J., April 26, 1907, Irene Dupont Young, M. D., aged 82. He graduated at the Jefferson Medical College, Philadelphia, 1848. He was a member of the Medical Society of New Jersey and of the Burlington County Medical Society of which he was the Historian.

Board of Health of the State of New Jersey —Monthly Statement, February, 1907.

The number of deaths reported to the Bureau of Vital Statistics during the month of February, 1907, was 3,340, an increase of 51 over the number reported during the previous month. By ages there were 493 deaths among infants under one year, 251 deaths of children over one year and under five years, and 1,091 deaths of persons aged sixty years and over.

Pneumonia shows an increase, the number of deaths from this cause for February being 444. The figures for the previous month were 332, and the average for the past six months 226.

Tuberculosis of the lungs caused 379 deaths, which is slightly above the average for this disease. The mortality from cancer continues unusually high, and diseases of the nervous system show the highest death rate for any period during the past six months.

The following table shows the number of certificates of death received in the State Bureau of Vital Statistics during the month of February, 1907, and also the number of deaths from certain selected causes.

Causes of death, and number of certificates received:

Typhoid fever, 44; measles, 16; scarlet fever, 15; whooping cough, 25; diphtheria and croup, 74; malarial fever, 2; tuberculosis of lungs, 379; tuberculosis of other organs, 60; cancer, 141; cerebro-spinal meningitis, 16; diseases of nervous system, 530; diseases of circulatory system, 406; diseases of respiratory system (pneumonia excepted), 290; pneumonia, 444; infantile diarrhoea, 46; diseases of digestive system (infantile diarrhoea excepted), 196; Bright's disease, 224; suicide, 27; all other causes, 405; total, 3,340.

Food and Drugs.—During the month of February, 1907, 171 samples were examined under the direction of the State Board of Health, in the State Laboratory of Hygiene, 22.3 of which were adulterated.

Bacteriological Examinations for Diagnosis.—During the month of February 635 specimens were examined for diagnosis, as follows: From suspected cases of diphtheria, 221; tuberculosis, 276; typhoid fever, 116; malaria, 6; miscellaneous, 16.

Monthly Statement, March, 1907.

The number of deaths reported to the Bureau of Vital Statistics during the month ending March 15, 1907, was 3,141, a decrease of 199 from the previous month. By ages there were 481 deaths among infants under one year, 236 deaths of children over one year and under five years, and 1,037 deaths of persons aged sixty years and over.

The number of deaths from suicide (31) shows a slight increase compared with the number of deaths from this cause which occurred during the preceding eight months.

Diseases of the respiratory system caused 1,002 deaths, as follows: Pneumonia, 413; pulmonary tuberculosis, 348; bronchitis and other affections of the lungs and air passages, 241.

The mortality from scarlet fever continued low (18), and the deaths from diphtheria (59) numbered less than the average for the preceding four months.

Diseases of the nervous system caused 441 deaths, the average for the preceding eight months having been 365.

The following table shows the number of cer-

tificates of death received in the State Bureau of Vital Statistics during the month ending March 15, 1907, and also the number of deaths from certain selected causes.

Causes of death; number of certificates received:

Typhoid fever, 39; measles, 9; scarlet fever, 18; whooping cough, 18; diphtheria and croup, 59; malarial fever, 1; tuberculosis of lungs, 348; tuberculosis of other organs, 28; cancer, 129; cerebro-spinal meningitis, 18; diseases of nervous system, 441; diseases of circulatory system, 346; diseases of respiratory system (pneumonia and tuberculosis excepted), 241; pneumonia, 413; infantile diarrhoea, 56; diseases of digestive system (infantile diarrhoea excepted), 164; Bright's disease, 185; suicide, 31; all other causes, 597; total, 3,141.

Food and Drugs.—During the month of March, 1907, 368 samples were examined under the direction of the State Board of Health, in the State Laboratory of Hygiene, 32 per cent. of which were adulterated.

Bacteriological Examinations for Diagnosis.—During the month of March 732 specimens were examined for diagnosis, as follows: From suspected cases of diphtheria, 265; tuberculosis, 330; typhoid fever, 121; malaria, 9; miscellaneous, 7.

Deaths from certain preventable diseases during the month ending March 15, 1907, in cities of New Jersey having 10,000 inhabitants and over:

CITIES	Population by census of 1905	Consumption	Typhoid Fever	Diphtheria
Atlantic City....	37,593	1	1	2
Camden	83,363	11	3	7
Bridgeton	13,624	2	0	0
Millville	11,884	2	2	0
East Orange	25,175	2	0	0
Montclair	16,370	3	0	0
Newark	283,299	71	4	17
Orange	26,101	12	0	1
Bayonne	42,262	7	0	1
Harrison	12,823	5	0	1
Jersey City	232,699	53	3	7
Town of Union..	17,005	1	0	0
West Hoboken..	29,082	3	0	0
Trenton	84,180	11	6	0
New Brunswick..	23,123	4	1	0
Perth Amboy ...	25,895	2	1	0
Long Branch....	12,183	3	1	0
Morristown	12,146	2	0	0
Passaic	27,836	8	0	1
Paterson	111,529	15	1	3
Elizabeth.....	60,509	11	0	2
Plainfield.....	18,468	2	0	0

Infantile Diarrhoea: 1 death each in East Orange, Montclair, Trenton, Morristown, Elizabeth and Plainfield; 2 each in Camden, Bayonne and Paterson; 6 in Newark and 11 in Jersey City.

Scarlet Fever: 1 each in Jersey City and Passaic; 8 in Newark.

PROPRIETARY PREPARATIONS APPROVED BY THE A. M. A. COUNCIL ON PHAR- MACY AND CHEMISTRY.

(Continued.)

BROMIPIN.

A bromine addition product of sesame oil, containing 10 per cent. of bromine in organic combination.

Actions and Uses.—Bromipin acts like the bromides, but as it yields its bromine more slowly it is thought to have less tendency to produce brominism. The combination is not broken up in the stomach, but a portion of the bromine is split off as soon as the oil enters the intestine. The oil

with the remaining bromine is easily absorbed, and, similarly to other fats, is largely deposited in the tissues, where it is slowly split up. It is said to be more lasting in its action than the bromides. Dosage.—4 Cc. (1 fluidram), increased in cases of epilepsy to from 8 to 32 Cc. (2 to 8 fluidrams); in emulsion with peppermint water and syrup, or pure, flavored with oil of peppermint. Manufactured by E. Merck, Darmstadt. (Merck & Co., New York.)

BROMIPIN—33⅓ PER CENT.

A 33⅓ per cent. brominated sesame oil. Manufactured by E. Merck, Darmstadt. (Merck & Co., New York.)

BUTYL-CHLORAL HYDRATE.

Actions and Uses.—Its action is similar to that of chloral, except that it is said to be less depressing and more analgetic. It has been especially recommended for facial neuralgia. Dosage.—0.3 to 1.3 Gm. (5 to 20 grains).

CALCIUM ICHTHYOL.

A derivative of ichthylol in which calcium is substituted for ammonium. Manufactured by the Ichthylol Co., Hamburg. (Merck & Co., New York.)

CALOMELOL.

A soluble colloidal form of calomel, containing albuminoids.

Actions and Uses.—Its action is the same as that of calomel, but it is claimed to be superior because of its solubility in water, acting more rapidly and efficiently. Calomelol is claimed to be non-irritant and particularly non-toxic. The indications for its use are the same as for calomel. Dosage.—Internally the same as calomel. Externally it is used as a dusting powder, mixed with an equal quantity of starch or of a mixture of starch and zinc oxide, or in the form of calomelol ointment. It should be guarded from the light. Manufactured by the Heyden Chemical Works, New York.

CALOMELOL OINTMENT.

Actions and Uses.—It is a substitute for mercurial ointment, over which it has the advantage of cleanliness, and it is claimed to be distinctly superior as an inunction in syphilis, etc. Dosage.—6 Gm. (90 grains) daily for inunction in syphilis. Manufactured by the Heyden Chemical Works, New York.

CASCARA EVACUANT.

A preparation said to contain a bitterless glucoside, obtained from the bark of *Rhamnus purshiana*, with aromatics.

Actions and Uses.—It is claimed that this preparation possesses the laxative properties of cascara sagrada without the bitterness which characterizes the ordinary extract. It is recommended for the treatment of chronic constipation, for which cascara sagrada is one of the best medicinal agents. Dosage.—As a laxative, 0.6 to 1 Cc. (10 to 15 minims) three times a day; as a purgative, 1.3 to 2 Cc. ((20 to 30 minims) morning and evening, 4 Cc. (1 fluidram) may be given in obstinate

cases. Prepared by Parke, Davis & Co., Detroit. CASCARA TONIC LAXATIVE GLOBULES.

Each globule is said to contain 0.2 Gm. (3 grains) of the bitter glucosides of *Rhamnus purshiana* suspended in a bland fixed oil, to which aromatics have been added.

Actions and Uses.—The manufacturers claim that it combines the laxative action of cascara with tonic properties of the bitter principle with the advantage of concealment of the disagreeable taste. Dosage.—One or two globules to be taken before retiring. Prepared by Parke, Davis & Co., Detroit, Mich.

CHINAPHENIN.

Chinaphenin, $\text{CO}(\text{NH}_2\text{C}_6\text{H}_4\text{OC}_2\text{H}_5)(\text{C}_{20}\text{H}_{22}\text{N}_2\text{O}_2) = \text{C}_{22}\text{H}_{22}\text{N}_2\text{O}_4$, the quinine carbonic acid ester of phenetidin.

Actions and Uses.—Chinaphenin combines the antiperiodic properties of quinine with the analgesic power of phenacetin, with the advantage of tastelessness and asserted freedom from symptoms of cinchonism produced by the administration of the two remedies in simple mixture. It is recommended in febrile diseases, especially la grippe; in spasmodic conditions, such as whooping-cough; in certain forms of malaria and in neuralgia. Dosage.—Adult: 0.3 to 0.6 Gm. (5 to 10 grains) ordinarily, 1.5 to 2 Gm. (22 to 30 grains), given in two doses as an antipyretic in neuralgia and malaria; in whooping-cough, 0.13 to 0.3 Gm. (2 to 5 grains), according to age. Manufactured by Ferbenfabriken, vorm. Friedr. Bayer & Co., Elberfeld, Germany. (Continental Color & Chemical Co., New York.)

CHLORBUTANOL.

Chlorbutanol, 1,1,1-trichlor-2-methyl-propan-2-ol, $\text{CCl}_3\text{C}(\text{OH})(\text{CH}_3)\text{CH}_2 = \text{C}_4\text{H}_7\text{OCl}_3$, produced by the reaction of acetone on chloroform.

Actions and Uses.—It is said to be absorbed unchanged, but to be decomposed in the body. It is a local anesthetic with an action weaker than that of cocaine, but sufficient to prevent vomiting from gastric irritation. Its antiseptic action is said to be fifteen times as strong as that of boric acid. It acts on the central nervous system similarly to chloral, and although the claim has been made that hypnotic doses are without effect on the circulation and respiration, independent observers have described a fall of blood pressure and interference with respiration in animals, and consider it fully as dangerous as chloral. In man 100 grains caused severe symptoms, but recovery occurred. It is claimed that no habit is induced, but this may be referable to its restricted employment. It is recommended as a mild local anesthetic, in dentistry, etc., as a preservative for hypodermic solutions, for insomnia, vomiting and for spasmodic conditions. It is also said to be useful as introductory to general anesthesia, lessening excitement and nausea. Dosage.—The dose is from 0.3 to 1.5 Gm. (5 to 20 grains) dry or in capsules. Hypodermically as a local anesthetic a saturated aqueous solution may be used.

The JOURNAL will be glad to print original papers from any source, preferably from members of the State Society, provided that they shall be of sufficient merit and shall be contributed to this paper exclusively.

Anonymous communications will not be published, but the name of the author of a communication will be kept secret if the editor is requested to do so.

The Medical Society of New Jersey does not hold itself responsible for the sentiments expressed by the authors of papers.

It will be satisfactory to all concerned if authors will have their contributions typewritten before submitting them for publication. The expense is small to the author—the satisfaction is great to the editor and printer. We cannot promise to return unused manuscript.

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THE TREATMENT OF ALBUMINURIA IN PREGNANCY.*

By Edward J. Ill, M. D.,
Newark, N. J.

You will permit me to say that I present this short paper, not as an exhaustive treatise on the treatment of albuminuria of pregnancy and its evil results, but simply as an experience of what has been my own work at the bedside. I present it to learn of those of you who are my seniors in years and experience, and therefore beg for a free discussion. No one goes to a case of uremia in pregnancy but what he feels the uncertainty of the prognosis, and the weight of responsibility, for two lives are at stake. You will permit me to begin with some rambling remarks and a few illustrative cases. Let me say whenever albumen is found in a woman we should never neglect to draw a specimen with a catheter for examination, to exclude any possible error.

The cases of albuminuria which come on early in pregnancy and without constitutional symptoms, and are discovered early by the careful doctor, are those which rarely give us any trouble, though always some anxiety. They are those which readily respond to diet, hot packs, calomel and saline purgatives. This is especially the case when the symptoms are mild, the percentage of urea slightly below the normal, and the quantity of albumen little, the quantity of urine near the normal, and the skin in a healthy, moist condition. These cases can often be allowed to go to full term

without interference. I have several times noticed, however, that the injudicious use of diuretics suddenly produced harmful results precipitating uremic symptoms. On the other hand, I have seen cases go on from the fifth month to term by careful but not exclusive diet and an occasional dose of calomel and Carlsbad salts. When I say "not exclusive diet," I mean not milk exclusively. I allow these patients fresh green vegetables, raw and cooked fruits, bread and light cakes, pumpkin, squash, white meat of fowl or veal, and now and then a lamb chop for a change. I always urge the drinking of large quantities of warm water and milk between meals. If they are accustomed to strong alcoholics, as unfortunately many American women are, I permit a glass of light claret. I never allow tea or coffee.

I have a case in mind that caused me much worry, because her doctor was her husband, and made daily tests of her urine. He would be especially aggressive when the quantity of urine was down below normal. I first saw her when she entered the fifth month of her second pregnancy. For several days she was on an exclusive diet, was kept in bed and treated as if she was a very sick woman. A drawn specimen of urine showed a marked trace of albumen, and now and then a hyaline cast. This exclusive diet had the result of producing a furred tongue and an upset stomach. She passed but twenty ounces of urine. I saw her with a view to bring on labor. There were no uremic symptoms in this very hysterical woman, and her anxious, book-learned doctor was her greatest enemy. A few doses of calomel and a saline cleared her tongue. She was allowed a more liberal table, and now easily took large quantities of milk and

* Read before the Newark (N. J.) Medical and Surgical Society, April 18, 1907.

water between meals. An occasional hot bath was given at bed time and on fair days she was out with the doctor in his buggy. She now passed more urine, but always had some albumen. By this sort of treatment, and a little carbonate of iron as a medicine, she went to full term and a normal delivery. So far as I know she is well at this date. The conditions as seen in this patient seem equally frequent in primipara and in the multipara. These patients should not be kept in doors, but should have some outdoor exercise. They should be carefully guarded against colds and wet feet.

Albumen in small amounts discovered late in pregnancy should be looked at with more suspicion, and needs very close attention. Here, in spite of careful general treatment, the condition may get rapidly worse. The skin gets parched and dry, urine and urea decrease, while albumen increases. There is early oedema of the legs and lower eyelid. Such cases will not tolerate procrastination, but early labor should be induced and the pregnancy terminated. I would not wait for general uremic symptoms. Often we cannot give the patient enough time to bring on labor and forestall a catastrophe. We often meet cases where albumen and uremic symptoms come on at the same time, and progress so rapidly that nothing short of the most heroic treatment will offer a chance for life. The following case of this kind came under my notice recently and showed the very good observation and the clearly defined demands of her doctor, a valuable member of this Society.

A primipara was perfectly well on Saturday when her urine was examined and showed no albumen. On Sunday evening she telephoned to her doctor asking for something to ease a headache which followed a large Sunday dinner. She was given calomel and a Seidlitz powder. Her urine in the morning showed a moderate amount of albumen. Her doctor found her very sick and getting worse in spite of free purgatives and hot fomentations over the kidney. She gradually passed less urine, and that was solid with albumen. I saw her on noon Wednesday, when her doctor had exhausted all resources in the line of medication. She was then very restless, had severe headache and slight dimness of vision. Her tongue was dry and her bladder contained but one ounce of urine, as drawn by the catheter. The last she passed was six hours previously. She was pregnant eight months and the foetus alive. The cervix was long and hard, and the head above

the pelvic brim. To induce labor meant 24 hours to bring on contractions and 24 hours for the birth of the child. Her doctor, who had observed her closely, insisted that she could not live that length of time and urged immediate delivery. To do a Cesarean section looked like a very extreme measure; to dilate a long, hard cervix meant a couple of hours of anaesthesia, very severe injury to the soft parts of the mother and likely a dead child. There seemed no choice but the former. The operation was set for 3 o'clock. Just as the anesthetist was sent for the patient, the report came of the first convulsion. The doctor's prognosis was thus confirmed. She was returned to bed in twenty minutes and a live child was born. Her uremic symptoms lasted for four days, though she had no further convulsions, and demanded the undivided attention of her doctor for that length of time. Several times we thought she would succumb. The treatment consisted mainly of ten minute drinks of milk and hot water and rectal enemata of normal salt solution every four hours, besides hypodermics of strychnine and digitalis to keep her heart going. Her urine gradually and steadily improved so that she passed thirty ounces during the second twenty-four hours. These two extreme cases illustrate very well that the indications may widely differ in the various conditions that present themselves.

I am often asked will it be safe to allow a woman to go through any more pregnancies when once she had uremic convulsions or albuminuria. The answer is rather difficult, and so far as I am concerned, I wish no one a cheerless old age. My first case of convulsions was seen in October, 1876, in a primipara. She was treated after the method of Carl Braun with rectal enemata of chloral hydrate. She had many convulsions, but got entirely well. Later she gave birth to many more children, with never a recurrence of albuminuria. The extreme on the other hand would be represented by the following history, which was kindly given me by a valuable member of this Society, as I had seen the woman early in this pregnancy and on other occasions:

Mrs. D.: age 30; U. S. Family history: Her mother had had eclampsia with two pregnancies, following which she drifted into a condition of mental weakness. Her father is alive and well. Present history: She has been married for five or six years. With her first pregnancy she passed urine which contained albumen at various times, but it was always of low specific gravity, and

the amount of urea was low. Microscopically there was nothing found. She miscarried a dead foetus at the sixth month, and had an uninterrupted convalescence. About a year after she became pregnant a second time. The urine was examined weekly, and did not contain any albumen. For the whole nine months it was almost uniformly 1020, acid, no albumen and no sugar. The microscopical findings were negative and the urea normal. At this time she was drinking a large amount of water and spending a large part of the day out of doors. She was delivered normally of a baby girl, weighing eight pounds, and her puerperium normal to the twelfth day, when she had a severe convulsion. This was repeated a second and a third time. The day previous the nurse had recorded a smaller amount of urine passed; a specimen of this urine showed a trace of albumen. This disappeared on the succeeding day. But the urea in both of these specimens was low. Another feature of unusual interest was the fact that her pulse was low. On the day of the convulsion and on several preceding days it was from sixty-six to sixty-eight. On the day preceding the eclampsia she also complained of a severe occipital headache and of some mental dullness. She was given daily hot packs and cathartics, and from this time on had an uninterrupted convalescence. This woman just escaped a severe illness. It seemed bad enough as it was; but she is happy with her baby. After observing many cases of this kind I had hoped to be helped in my indication for action by classifying the cases as to their character. In doing so I have always kept the condition of the primipara and that of the multipara separate, for reasons that I shall speak of later.

In discussing albuminuria of the primipara, we must take into consideration three cardinal conditions:

- 1st. The character of the albuminuria.
- 2nd. The presence of uremic symptoms.
- 3rd. The time of either one or both in regard to pregnancy, and the condition of the soft parts.

From these conditions it has been my custom to consider each case as coming under the following eight sub-divisions in regard to treatment:

1. A primipara having albuminuria of moderate degree but no uremic symptoms before the viability of the child;
2. A primipara having albuminuria of severe degree and no uremic symptoms before the viability of the child;

3. Having albuminuria of severe character, but no uremic symptoms before term, but far enough advanced for a viable child;

4. Having albuminuria of severe character, but no uremic symptoms at term and not in labor;

5. Having severe albuminuria and uremic symptoms long before term and before the viability of the child;

6. Having severe albuminuria and uremic symptoms at or near term, but not in labor;

7. Having uremic convulsions at term and no dilatation and no symptoms of labor;

8. Having uremic convulsions in labor and free dilatation.

In the first of these close observations only slight change of diet and an occasional purge of calomel and a saline, is all that is necessary. If any anemia accompanies the condition, and no kidney or few kidney elements are present, the saccharated carbonate of iron has proven beneficial in my hands. In the second condition we are confronted with a much more severe problem, for slight uremic symptoms may supervene at any time. Here again a calomel and saline purge should constitute our treatment. I have learned much from a case of this kind treated in conjunction with the late Dr. Lehlbach, when I was a young man. For several days we gave the patient 2 grs. of calomel t.i.d and a Seidlitz powder in the morning. The result was an entire disappearance of the albumen and a happy outcome. Hot baths, hot packs, strict milk diet, large drinks of warm or hot water should be ordered. If we can carry the patient on until we have reached the third condition—when she has a viable child and the albuminuria does not improve, our duty to induce labor is plain.

The same can be said of the fourth condition—when the patient is at term but not in labor, and the albuminuria does not improve speedily under the foregoing treatment. Conditions immediately change when we have uremic symptoms accompanying the albuminuria under the fifth condition, i. e. before the viability of the child. Fortunately this dilemma does not often occur. I have seen it but once, and in sufficient time to induce labor. When we come to the sixth condition we must not tarry. If the uremic symptoms are slight and slow coming, induced labor may still help us. If the uremic symptoms are severe and coming on rapidly, Cesarean section should be our choice. When the seventh condition arrives, i. e. when we have convulsions at term and

no dilatation, the indication is only met by a Cesarean section. In the eighth condition we can carry the patient along for a few hours by the use of chloral hydrate enemata, veratrum viride, normal saline enemata or subcutaneous infusion, until it will be safe to apply the forceps or more rarely turn through a dilatable or preferably a retracted cervix.

You will have noticed that I said nothing of turning through a slightly dilated cervix, nor of an accouchement force. Both give the child but a bare chance, and injure the mother beyond any chance of repair, if she should be so fortunate as to escape with her life. The injuries I wish to speak of in this regard are the deep cervical and vaginal lacerations and sloughing that produce atrophy of the pelvic cellular tissue. More than once I have had a chance to verify that the lacerations have gone into the broad ligament, and even into the peritoneal cavity.

At any time when delivery per vaginam seems difficult because of the long, narrow cervix, Cesarean section should follow. I have no experience with the Duersen vaginal Cesarean section, but remembering that the lower segment of the uterus contains erectile tissue, I would urge as little injury as possible. I have spoken of the primipara under separate head because the obstacles met with are infinitely more severe than in the multipara.

With the advent of uremic symptoms in the multipara relaxation takes place. The soft parts readily dilate and delivery is accomplished with comparative ease. Thus far we have never been obliged to do a Cesarean section for convulsions in the multipara. Since we have done Cesarean sections for convulsions, i. e. for seven years, we have not met with any multipara who has not been at term and in labor. The method which I have used to induce labor since the autumn of 1877, was to introduce a funnel-shaped bag of small size into the uterus, through a Sims speculum, filled with water with an ordinary piston syringe. I was always careful to gauge the quantity of water, by filling the bag beforehand. One can also gauge the size of the bag by its tensivity, as water is being injected.

It is not sufficiently established that the character of the crystals found in the urine indicates the presence or identity of lithiasis in the urinary tract. When cystin crystals are constantly found in the sediment, however, if symptoms of lithiasis are present, the stone is probably made up of cystin.—*Amer. Jour. of Surgery.*

VAGINAL TEARS PRODUCED DURING LABOR AND AN OPERATION FOR THE SAME.*

By Swithin Chandler, M. D.,
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Suppose, for an instant, we refresh our minds by stating the anatomy of the walls of the vagina and the relation it bears to the bladder and rectum. It may thus give us a better grasp of the subject of tears of the part and help in the after suggestions and thoughts expressed in the paper brought forth by the title, namely, "Vaginal Tears Produced During Labor." The vagina is a membrano-musculo connective tissue tube uniting the uterus above, surrounding the cervix uteri in parts, and having its outlet between the labia.

It is connected to the bladder in front and the rectum behind, at least two-thirds of its length by connective tissue, and is surrounded at its lower third by the levator ani, the constrictor vaginae, the urogenital trigonum muscles. It is composed of three layers of tissue, mucous membrane on a basement of fibrous connective tissue, a muscular and an outer sheath of connective tissue. The mucous membrane forms on the anterior wall a longitudinal ridge near the median line, from which folds of mucous membrane go out, forming rugæ. The same is also true of the posterior median line, but not so marked. These are the so-called anterior and posterior columns. The anterior column ending in the tubercle of the vagina. The arteries are from the anterior division of the internal iliac and its branches. They are the vaginal, uterine, vesical, middle hemorrhoidal and the internal pudic. The vaginal arteries on either side anastomose with the circular artery of the uterus, forming the azygos arteries of the vagina, which are in the median line of the vagina anterior and posterior. The veins form a rich network communicating with the surrounding parts and the broad ligament, finally emptying into the internal iliac vein. The lymphatics from the lower third empty into the superficial inguinal glands, those from the middle third into the glands of the pelvis, the upper third combine with those of the cervix. The nerves are from the sympathetic communicating with the hypogastric.

The tears of the vagina are many times

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contained into or from the perineum and other surrounding parts, but to-day we wish to speak only of the tears of the vagina, and the ruptures into the surrounding or neighboring parts will be mentioned only incidentally. The tears are longitudinal, transverse, or oblique. They are clean-cut, ragged or teased and gangrenous. According to their depth, vaginal tears are for convenience sake divided into submucous, mucous and muscular, and complete severing or partially so of the levator ani, or the urogenital trigonum muscle. The submucous tears are those where there is no evidence of injury on the mucous surface and are usually simply muscular separations. The mucous tears are those that extend to the levator ani and deeper muscles, but do not affect them. The complete tears are those where the levator ani and the deeper muscles are partially or wholly divided. This classification is made in order that the operation later to be described may be more thoroughly understood. It also has the advantage that it closely adheres to the anatomy of the vagina.

These vaginal tears are produced by the head of the coming child, its shoulders, the hands of the operator or the instruments. It is unnecessary to explain in this paper the part that these play in the production of tears, except to emphasize the fact that many tears are produced by the after-coming shoulders, and many times a previous tear is made worse by them. The instruments are too many times blamed when a tear is due to the shoulders or the pressure of the head. At this time let me say that many cases of relaxed vaginal walls are almost impossible to foretell at the time of the delivery, because the tear is submucous, the mucous membrane showing no evidence of injury. The parts are so dilated that it is at times impossible to diagnose such an injury as a submucous tear, and the obstetrician should not be criticised because of this fact at a later period.

We now approach the treatment of this condition of tears of the vagina. First of all, the best treatment is the avoidance of such injury. This is much easier to preach than to accomplish, because no matter how skillful the accoucher may be, the tears will produce themselves, and we should be most chary in condemning a practitioner after such results. The greatest care in the world will not avoid vaginal tears. He who never has tears of the vagina in his practice is he who has had no experience, or one who is a relation of a certain Biblical character. As

to the immediate repair of such injury to the vaginal walls, it is many times of a simple character to bring the parts to their original situation by means of a few well-placed sutures. Other times it is very difficult, and at times inadvisable, in my judgment, to even attempt an immediate operation. For instance, in the gangrenous sloughs or the ragged tears. To close up such parts is to invite sepsis, and no keen observer is needed to explain this suggestion when we remind ourselves of the lymphatics, and we recall the easy infection that may occur to these dying and unresisting tissues.

The intermediate operation, that which is performed within a week, depends upon its endeavor and attempt, upon the tissues themselves, and the condition of the patient. If all is well, we can, as you all realize, I believe, curette the granulations and then, by well-chosen sutures, restore the parts to their normal. The secondary operation is, in many cases, the only operation that can be performed. For years we have struggled to perfect such a procedure, and, with your permission, I will detail an operation which I have been performing for several years. After carefully watching the results, I have the pleasure to present the operation to-day. You are all familiar with the Emmet, because we were all taught that operation. The Hager is merely to remove a triangular piece of mucous membrane. The modification which Kelly performs, is also well known. Morton recommended removing two triangular portions of mucous membrane from the sulci of the vagina, leaving a central strip untouched, and to this the edges of the denuded membrane are sutured. The Fehling is a modification of this. Other operations have also been recommended, all having the same idea, namely, the removing of the strips of mucous membrane.

Let me for a moment read a passage to confirm this, taken from "Garrigues Diseases of Women," p. 333: "Third step, that is, all the *mucous membrane* between the top of the rectocele, the two carunculæ myrtiformes on the side of the vaginal entrance, and a curved line running a quarter of an inch inside of the posterior circumference of the rima pudendi, and parallel with it, is denuded, and sutures are put in from side to side." Thus we see that, as before related, the idea is to denude the mucous membrane. If we now refer to the anatomy of the vagina, what do we find—that all tears of the different degrees are repaired according to this advice. The old scar tissue be-

tween the fibrous or muscular layers remains untouched, or is merely folded in when we unite the denuded membrane. Again, the said muscular and fibrous layers are not perceptibly approximated, but are, if anything, placed in an abnormal position, and held so by adhesions between the two mucous denuded surfaces. This of course makes a big bulk, but adds nothing to the strength of the parts or, at most, only temporarily. This membranous union soon gives way under pressure and domestic acts with the result that the vaginal walls resume the same condition that existed before the operation. Therefore realizing that the operations as performed were not as satisfactory as desired, and stirred by a few words spoken by Dr. Kelly at one of his public clinics, I attempted to further my endeavor in this line, and now present for your consideration and judgment, my results, and the operation which I think has overcome the objections of the other operations, and it has been demonstrated to my satisfaction, and to the satisfaction of a few other operators who have been kind enough to try it.

It is as follows: At a point one-half an inch or so below the attachment of the cervix and the vagina, in the posterior median line, according to the previous rupture, I place one tenaculum. At the outer edge of the vaginal opening, corresponding to the normal vaginal canal, another is placed. Directly opposite this, on the other side of the vaginal outlet the last tenaculum is placed; thus we have a triangle, as in the Hager operation. By traction the vagina is made taut, and the triangle comes into view. The lines are marked deeply by a scalpel, then the first tenaculum, which corresponds to the apex of the triangle, is drawn upon and an incision is made clear through all the layers of the vagina in the line of the cuts forming the triangle, just large enough to engage one finger. By a slight pressure of this finger the lines cut give enough to admit two fingers; the second finger is then introduced and both fingers are pressed forward, opening like a pair of scissors, and by pushing them between the rectum and the vagina the whole triangle is separated and rests upon the fingers, ready to be removed by the knife or scissors. Now the edges are approximated by sutures, thus making a new vaginal wall, all the scar tissue and relaxed tissue having been removed with the removal of the triangle, and all the tissue of similar structure united—connective tissue to connective tissue, muscle to muscle, and mucous membrane to mucous mem-

brane, edge to edge. The anterior vaginal wall, if ruptured or torn, is treated by removing the entire layers of the vaginal wall, and the same procedure is carried out, and the same results obtained. One can deviate, if it is required to take out any scar tissue. The operation is performed in as short a time, and after a few trials, in a shorter period, than with the older methods. There is a little more bleeding, which can easily be controlled by sutures.

The advantages of the operation appeal to me as follows: 1st. It makes a vaginal wall as near to the natural and normal wall as it is possible. 2d. It removes all diseased or scar tissue. 3d. It exposes the levator ani, or the urogenital trigonum muscle, which can be caught up and united. 4th. It renders perineal operations more easily accomplished. 5th. It prevents future relaxation of the vagina, because the different tissues are united to the tissues of the same class. 6th. It does not leave a tissue that can be drawn apart as with the old operation. 7th. It permits union between the rectum and the vagina, braces both, preventing constipation. The same may be said of the bladder, allowing such adhesions to form as existed originally. 8th. It will, in many cases, relieve permanently constipation and bladder complications, while the other operations, because of their incompleteness, do so, if at all, only temporarily. 9th. The field of the operation is always before the operator; there is, therefore, not so much danger of injuring the rectum, as in the snipping operations. 10th. The scar produced is thin and strong. 11th. The vagina after this operation is supported by some of the surrounding parts, and in return helps to support the surrounding parts.

In conclusion, permit me to state that it is my experience, when secondary operations are performed, the obstetrician is to be congratulated upon the fact that the tear is not as great as it would have been, except for his skill and attention; that he has shown the greatest judgment in waiting, and had such judgment not been exercised, had he not wisely deferred the operation, the patient would have been the sufferer; that where extreme tears have resulted the most difficult cases have been handled, and the woman may well congratulate herself upon her recovery; that in rare cases indeed should any of us be judged harshly; on the contrary, in most instances much credit belongs to the physician.

THE FASHION OF DIETING.*

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Man is an animal of extraordinary adaptability to his environment, and one must be consequently guarded in making dogmatic statements in regard to his diet. It is safe, however, to assert that a mixed diet—both animal and vegetable—has produced the most successful races; that the staple food of any race or the limited diet of a company of people is certain to be free from high flavor, as bread, boiled rice, boiled meat or fish or the pemmican of the explorer, and that almost universally in the past the vegetarian has paid tribute to the more active flesh eater. As an exception to this rule, however, the Polynesian warrior is more ferocious at times on a diet of plantain than the Esquimo who eats nothing but meat, fish or fat. Man accommodates himself so readily to a great variety of food-stuffs that the Esquimo on his diet of blubber, the Jap on his rice and fish or the native of Central Africa on his fruits, endures as well apparently as those who dine upon the most refined and epicurean dishes. Nor is there danger from periodic gorging. The savage gorges himself when food is abundant; then sleeps like an animal till hunger arouses him to renewed activities. The gourmand of classic days took an emetic to relieve his stomach that he might partake of delicacies yet to come.

The human animal then withstands quality and quantity. He survives on the simplest diet or maintains a reasonable degree of health during prolonged feasting. What he can not endure, though, is dining during great anxiety, and if dread arises from the belief that certain portions of the menu are harmful the constant introspection caused by the conviction that he must abstain from what others are eating will surely inhibit digestion and more harm will ensue than from the most reckless indulgence. It is as true to-day as at the time of Proverbs were written, that, "Better is a dinner of herbs where love is than a stalled ox and hatred therewith." While unpleasant emotions affect digestion unfavorably, mirth and freedom from care affect it favorably. "Laugh and grow fat" is certainly not without physiological basis.

Hufeland wrote: "Laughter is one of the

greatest helps to digestion with which I am acquainted." The custom of our forefathers of exciting it at table by jesters was founded on true medical principles. How can there be contentment, or laughter or good digestion for those who believe that menus are elaborated and dishes multiplied only that they may have more to fear and avoid. Why then the fashion of dieting? Why does the lean man on your right at table avoid all fats and the person on your left abstaining from sweets say, "Do you eat that, doctor? I know you would not allow one of your patients to taste it." Where do they get the impressions? Are we responsible for these delusions? Can we be blamed for the misery of those who come to table to hunt out things that will disagree with them? I am not speaking of persons with typhoid, diabetes or nephritis symptoms, but of the ordinary individuals who make up our clientele and who are less healthy and less happy because of the notion of dieting. Nor do I fail to recognize the fact that where food is so easily procured more is eaten than is required to conserve strength. The many fasts of the early church perhaps were introduced less as a religious duty than as a wise method of correcting the gluttony of that period. Not of these, but of the rather large class of people, who say to you, "Tell me just what I may eat, and what not to eat." Those who, denying themselves, invite unhappiness and indigestion by constant introspection. Many of these patients have been so taught by us. I believe it is often harmful to suggest the avoidance of certain foods to nervous patients, and it is the *suggestion*, not the food, that is injurious. Harmful to distribute the diet slips so generously furnished us by manufacturers of patent foods—slips that recommend restricted diet in all conditions, and the use of their particular product at all times. The statement made by a New York specialist in a rather famous essay on infant feeding—that a meat diet can not make muscle is surely wrong and misleading. The Indians of the North leave their little villages early in winter and go back into the wilderness to trap, each family taking a little tea and flour, perhaps fifty pounds of the latter, to supply them till spring. When the baby is weaned it eats meat or meat broths or fish and nothing else, and these same babies grow up to be as fine specimens physically as any men on earth. We should be particularly careful about depriving out patients of sweets; desserts are not indigestible except for the fact that they are usually

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eaten after the appetite has been satisfied by the so-called substantial food. Composed mostly of milk, eggs, sugar and fruit, eaten after a small meal, they are beneficial. A fault of many households is to deny the children some of the dishes set before them. This is especially true of sweets. Sugar is excellent food for the active little bodies. The army medical officers have increased the sugar ration, combining it with chocolate for this purpose. The definition of an army given by a famous general as "an animal that crawls on its stomach," indicates the importance of sufficient and proper food for the soldier. Children, too, consider it unjust to be deprived of food that their parents are eating. But, above all, in placing food before them and then insisting upon their refraining from its use, the suggestion of the injurious effects of certain foods is repeated at each meal, dread and introspection follow, and so at an early age the pernicious habit of dieting is formed.

We do harm if we suggest any restricted diet to the poorly nourished dyspeptics that haunt our offices. The first and perhaps only advice given should be "stop dieting"; eat everything and balance it by sufficient exercise in the open air." I have great respect for the doctor who, after listening to the tale of woe that his new patient recited, asked but one question—"Does your wife make mince pies?" "Oh, yes," answered the sufferer, "we have them, but, of course, I never taste them." The advice given him was as brief as the query—"Go home and eat a whole one."

SOME POINTS IN PHYSICAL DIAGNOSIS. WITH SPECIAL REFERENCE TO CROUPOUS PNEUMONIA.*

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In forming conclusions from physical signs we must bear constantly in mind what seems almost too trite to require mention, *viz.*, that physical signs are but the induced expression of physical conditions, the language by which we interpret the state of the tissue under observation. Theoretically this language should be consistent, and the words indicating to us the information we are seeking should make up a sentence at

once intelligible and conclusive. Thus dullness on percussion should always mean an absence of air from the tissue percussed, and the more complete the dullness the more solid the structure; absence of tactile fremitus in observations of the lungs—that there is something interfering with the transmission of the voice vibrations from the lung to the observing hand; bronchial breathing and bronchophony should always mean a condition of lung consolidation. And so we might continue the illustrations. Unfortunately, however, the language of physical diagnosis is not a simple one, and many apparent contradictions are constantly met with, so that to one unversed in its intricacies many a misinterpretation will be made through failure to recognize the possible variations in physical conditions.

To be a successful practitioner of physical diagnosis one must have not only the ability to recognize physical signs, but also the ability, which comes only through large experience at the bedside and post-mortem table, to reconcile conflicting signs and, from the preponderance of the symptoms and signs, render a decision that will withstand a rational analysis. One is called, for instance, to attend an individual taken suddenly ill with a severe chill, followed by high fever, pain in the side, decided gastric disturbances, an eruption of labial herpes, all the symptoms, in fact, regarded as typical of croupous pneumonia. Examination of the chest shows, it is true, an extensive area of dullness over the base of one lung anteriorly and posteriorly, involving perhaps the entire lower lobe, but at the same time over this dull area absence of tactile fremitus will be noted, breath sounds absent, voice sounds absent; there is not the increased fremitus, bronchial breathing and bronchophony that one felt confident of finding when first undertaking the examination of the case. With what then are we dealing? Have we been in error in the conclusions arrived at from the symptoms, and have we really before us a case of pleural effusion and not croupous pneumonia? The signs are contradictory and at direct variance with the symptoms; experience must come to our assistance to enable us to arrange our facts so that the actual condition may be demonstrated. Let us first seek the position of the viscera adjacent to the lungs, the displacement of which by hydrostatic pressure constitutes one of the most valuable signs of pleural effusion. These viscera are found to be occupying their normal relations to the lungs, and we are brought face to face with the problems

* Read before the Gloucester County (N. J.) Medical Society, January 17, 1907.

of reconciling the conflicting and contradictory physical signs with the existence of croupous pneumonia. Those who have had an extensive experience with this form of pneumonia, and have carefully observed their cases, will know that every now and then a case is encountered in which these aberrant physical signs constitute a puzzling phase of the diagnosis, and that they are explained by the fact that the main bronchus communicating with the consolidated area becomes plugged by a large mass of tenacious mucus, which, while of course not interfering with the dullness upon percussion, does cut off the air entering the consolidated area and causes absent breath sounds; and by preventing the voice vibrations from reaching it, causes the absence of bronchophony which we regard as so characteristic of croupous pneumonia. The truth of conclusions thus gleaned from our experience with the disease may not be verified until the post-mortem table is reached, or may be confirmed by the displacement of the plug of mucus from the bronchus during life with the consequent appearance over the area of dullness of the characteristic signs of consolidation.

As certain cases of croupous pneumonia resemble in their physical signs cases of pleural effusion, so also one encounters instances of pleural effusion in which some of the signs closely simulate those of croupous pneumonia. It is within the experience of most of us to have seen cases of pleural effusion in which, upon auscultation, instead of finding absent or diminished breath sounds and absent or diminished vocal resonance, actually to observe bronchial breathing and bronchophony of the purest types. Here again are strongly contradictory signs, and it can be readily understood how, with percussion dullness and auscultatory phenomena properly associated with consolidation, such a grouping of physical signs may be mistaken as indicating croupous pneumonia. Again a closer observation becomes necessary to clear up the diagnosis; associated physical signs must be looked for and, as previously hinted, the most important of those significant of pleural effusion are visceral displacements; so that if the heart, liver, spleen and mediastinum are displaced, and tactile fremitus is notably diminished or absent, it is safe to make a diagnosis of pleural effusion, notwithstanding the presence of bronchial breathing and bronchophony. Just why these signs should ever be present with pleural effusion is a question difficult to find an answer for; it is prob-

able that some variation of tension with which the fluid is contained in the pleural sac may be responsible for it; or it may be that old adhesive bands stretching across the pleural cavity from the lung to the costal pleura serve as conductors for the transmission of breath and voice sounds to the chest periphery. Be the cause what it may, our experience and observation must have been extensive and acute enough to teach us that cases presenting these contradictory signs *do* occur, and that we must be prepared to meet with them. A physical diagnosis is very like a court verdict; only rendered after all the evidence is taken and the summing up has reconciled seemingly contradictory factors; the verdict should then be given in accordance with the weight of evidence. No one, not even the most expert and experienced diagnostician, will be free from mistakes; the best is he who makes the fewest.

We have now entered upon that season of the year during which we may expect to encounter croupous pneumonia in its greatest prevalence. In a series of 706 cases that I recently analyzed, occurring in the practice of my colleagues and myself in the Philadelphia General Hospital, 355 entered our wards during the months of January, February and March; the number of cases during these three months, therefore, being more than fifty per cent. of those for the entire year. In responding to your request, therefore, to say something upon physical diagnosis and diseases of the lungs, it is seasonable at least to make some remarks about this disease. The disease, as we observe it in the previously healthy young adult, the fully developed, frank and sthenic type of the disease, is so familiar to all of us and the physical signs are so characteristic that no allusion to this form need be made, save in one particular. I prefer, rather, to refer to the deviations from the typical in those forms of pneumonia which are sometimes alluded to as aberrant. The exceptional particular in ordinary, everyday pneumonia is this: After the onset of the disease it is usually twenty-four or forty-eight hours before the signs of the lesion become plainly manifest. During this interval how can one determine the seat of the developing lesion? After the severe initial chill, followed by high temperature and full, bounding pulse and other symptoms that cause us to suspect a developing pneumonia, while locally this is the period of engorgement and congestion, before the beginning of exudation, therefore anterior

to the occurrence of the crepitant rale; how can we at this time determine with any degree of probability by a physical examination that portion of the lung that is about to present unmistakable signs of a lesion? Our main resource is in a modification of the percussion note, confirmed by the discovery upon auscultation of an enfeebled breath sound. With a developing pneumonic lesion the first change in the percussion note is that from normal pulmonary resonance to a note that is distinctly tympanitic in quality, this gradually changing and finally merging with the dullness that characterizes fully developed consolidation. This tympany preceding consolidation, even the crepitant rale and the pouring out of the exudate, is dependent upon the engorgement of the lung and consequent relaxation of the pulmonary tissue. To obtain the normal resonant note over the lung we must have not only a normal lung, but that lung must be contained within the chest in a condition of vital tension. If that tension be altered, even though the lung itself undergoes no change, the result is a modification of the percussion note. Percussion of the normal lung upon the post-mortem table yields not pulmonary resonance but a tympanitic modification of pulmonary resonance. So, too, in the engorged stage of croupous pneumonia, the lung itself has not as yet undergone changes sufficient to modify the percussion note, but the afflux of blood to that portion of the lung the seat of lesion so relaxes the pulmonary tissue that its vital tension becomes lost and tympany, not pulmonary resonance, is the percussion result. Time and time again will one thus be enabled to make not only an early diagnosis of croupous pneumonia, but also to indicate the region that later will show evident consolidation signs.

Pneumonia happening intercurrently with emphysema is often the terminal event of that disease. Owing to the changes in the lungs incident to emphysema the physical signs of pneumonia may be most obscure. Dilatation of air vesicles and the mergence of large numbers of contiguous vesicles into one large vesicular bleb, make a space which the exudate of the disease under consideration is inadequate to completely fill with the result that an incomplete consolidation takes place, so that the dilated air vesicles are filled partly with air and partly with exudate. Of course a marked modification of the ordinary physical signs results. Tactile fremitus is not markedly increased, as the air remaining within the air vesicles pre-

vents its transmission; bronchial breathing and bronchophony are likewise only partially developed, as the consolidation is only a partial one and the air remaining within the vesicles further materially modifies these signs. In emphysema, as we know, the dyspnoea is chiefly an expiratory one; this is due to the inability of the air vesicles to expel the air owing to their loss of elasticity, upon the possession of which in health the expiratory portion of the respiratory act largely depends. On account of this loss of elasticity the air vesicles are never completely emptied of air, so that the residual air within the lungs is always in excess and the vesicular walls are never in contact with each other, or, at least, are always far removed from any approximation. In croupous pneumonia the crepitant rale depends upon the air vesicle being filled, or partially filled, with a semi-fluid sticky exudate, so that when, during expiration, the walls of the air vesicles attain their closest degree of approximation the vesicle is completely filled with exudate. When the vesicular walls draw apart from each other during inspiration the exudate sticking to them is pulled with them and drawn out into little bands or filaments which, at the end of inspiration, having been pulled out to their limit, separate with a snap and give rise to the auditory phenomenon of the crepitant rale. When a pneumonic lesion invades an emphysematous lung this mechanism is interfered with; the vesicular walls are not everywhere covered with exudate, the movement of the vesicles is limited and restricted by the loss of their elasticity, and as, in consequence, the inspiratory and expiratory excursions is but slight, the crepitant rale is not produced and we thus have an absence of one of the most important signs of pneumonia. Absent crepitant rale, but slight if any increase in tactile fremitus, only obscure bronchial breathing and bronchophony render the occurrence of pneumonia in emphysematous subjects very difficult of recognition and calls for the very highest diagnostic skill.

Among other aberrant forms of the disease the so-called central pneumonias present very difficult diagnostic problems. Here the lesion is deeply seated, about the root of the lung or deeply within a lobe. Everywhere it is surrounded by normal pulmonary structure which intercepts the signs of consolidation. We have not even the symptom pain to assist us, for pneumonia in itself is not a painful affection, and it is only when associated with pleu-

ritis that the very characteristic stabbing pain in the side is present. With normal pulmonary structure surrounding the lesion the dullness of the underlying consolidation will not be apparent, bronchial breath sounds and bronchophony alike absent and, of course, no crepitant rales to be heard. Here we must pay attention to the slightest variations from the normal: a slight impairment upon percussion, and distant, obscure bronchial breath sounds and bronchophony. I have already mentioned the early modification of the percussion note with a developing lesion as being one of tympany; a tympanitic note is nearly always to be made out in pneumonia in the neighborhood of the lesion, and always as the lesion is advancing. So, too, in central pneumonia the percussion note directly over the lesion may possess a tympanitic quality, and this often offers one material aid in arriving at a diagnosis. Within the last week I have watched for days a case of central pneumonia in which the slightly tympanitic note with some enfeeblement of the respiratory murmur were the only physical signs of the deep seated lesion, and watched it too, with a confidence which was realized, that the extending lesion would ultimately reach the periphery of the lung and declare itself by unmistakable signs. And so a considerable proportion of central pneumonias will do within three or four days; others, however, remain central throughout the course of the disease, with physical signs so obscure that by the symptoms alone can we make a diagnosis.

Pneumonia in the aged presents some peculiar physical features, and important it is to give these careful consideration, for after the sixtieth year of life this malady, of all acute diseases, constitutes the cause of death in a preponderating proportion of cases. Difficult, too, at times, is the disease of recognition, with signs most obscure and symptoms grave and of the asthenic type. The attack beginning insidiously, symptoms non-characteristic, cough absent, pain absent, temperature but slightly elevated, great prostration, pulse rapid and feeble, nervous symptoms predominating the clinical picture, examination of the chest reveals physical signs illy-defined and of a changeable character; only a few crepitant and other rales of a shifting character, and poorly developed bronchial breath sounds and bronchophony. Notwithstanding, also, the gravity of the symptoms, it is not unusual to find the extent of the lesion in striking disproportion with them. In fact, in many of these cases it seems to be the

general infection and not the extent of the local lesion that is chiefly operative.

In infancy croupous pneumonia, though very different in its symptomatology from the disease in adult life, shows no aberrance in its physical signs except in the tendency of the lesion to involve the apex in preference to other portions of the lung. Knowledge of this apparent selection, therefore, emphasizes the necessity of examination of the apices in infancy and early childhood.

In alcoholics the only symptom may be delirium tremens, and as the physical signs may be obscure and the lesion a central one, great care in the examination of the chest becomes necessary. In fact, almost every case of delirium tremens should be regarded as an instance of pneumonia until the existence of the latter has been disproved.

Typhoid pneumonia, badly so named, is not the association of pneumonia and typhoid fever as a hybrid affection. It is a form of pneumonia in which the symptoms are of a very low and asthenic type, due not to the extent of the local lesion but to the toxæmia. Indeed, the lesion is often very slight, centrally located, the physical signs obscure and the symptoms not those characteristic of croupous pneumonia. These cases are really instances of a septicæmia due to the pneumococcus, which not infrequently may be obtained from the blood by culture. It is true that pneumonia does occur during typhoid fever as a complication, but it should be regarded only as a complication. The term typhoid pneumonia is also at times applied to those instances in which early localization of the bacillus of Eberth takes place in the lung, with the result that a lesion develops that is physically identical with the lesion associated with pneumococcus infection. In fact, the disease begins as does an ordinary croupous pneumonia, and is not to be differentiated from it until, after some days, a crisis having failed to occur, the characteristic symptoms of typhoid fever declare themselves.

The subject of physical diagnosis having been assigned to me, I have, of course, made little or no mention of subjective phenomena. It must therefore be borne in mind that in many of the instances I have made reference to, in which by physical aids alone considerable difficulty will be experienced in arriving at a diagnosis, much assistance will be derived by the association of such signs as are elicited, no matter how obscure they may be, with the symptoms that the case presents.

THE ASEPTIC CONSCIENCE.*

By J. W. Martindale, M. D.,
Camden, N. J.

It is not so many years ago that I heard a world renowned professor in one of our medical colleges make the remark that he had seen the practice of medicine go through at least a dozen fads as foolish as the germ theory, and he expected to see this same theory exploded like the rest of them. In operating, it was his habit to put his knife in his mouth while he was using other instruments, then take it out again and use it to enlarge his incision or to dissect out some growth, etc.

He made the statement that he had lost five women within a period of two months from puerperal fever. These cases were contracted from him, and were directly the result of contamination from his hands, he having performed an autopsy on a patient dying from peritonitis. His first case of puerperal fever developed about four days after the autopsy. During the next two months he delivered several other women, and he carried the infection from one to the other until finally five were dead. He decided to give up obstetrical practice for a time. This was done and after a few months had elapsed he resumed practice without any trouble from puerperal fever. He gave the class this history to enforce upon their minds the necessity of cleanliness, claiming that his own bad results were due to insufficient attention to the manner of washing his hands. He said dirt carried poison. He did not believe in the germ theory, but he did believe that dirt was the cause of infection.

He was somewhat of a pioneer in gynecological work and performed the ordinary abdominal operations of the present day, but his mortality was very high. Imagine a modern surgeon putting a knife in his mouth, then going into the abdominal cavity with the same instrument. We would hold up our hands in holy horror; how much more so when we know that the old gentleman had very bad teeth and was probably suffering from pyorrhoea alveolaris, thus placing pus germs in the abdominal cavity at every stroke of his knife. I do not wish to criticise the memory of the dear old man, who has gone to his reward; he did not quite see the light, but was reaching after it. He did not hesitate to acknowl-

edge his failures and to try to point out to his students the way to avoid the pitfalls into which he had fallen. His instructions were: "Wash your hands in soap and water, cut your finger nails and wash your hands in carbolic acid and water."

Ever since the advent of the germ theory the efforts of the physicians have been directed to the destruction of bacteria on the surface of the part to be operated on and also on the hands of the surgeon, his instruments and dress. Volumes have been written on the subject of preparation of the hands, yet Kelly says that after scrubbing the hands with soap and water thoroughly, and then going through a bi-chloride solution bacteria were found on the hands of his assistants. No matter how carefully you may scrub the hands you cannot be sure you have eradicated the poison you have placed there by opening an abscess, or handling a case of puerperal fever, erysipelas, or carbuncle. I saw a physician open up four abscesses, dress an ugly carbuncle, getting his hands covered with infected matter, then go straight to the room of a woman and attended her in labor. After dressing the carbuncle he washed his hands in soap and water, bundled his instruments into his case and drove off. What was the consequence? His hands were infected, the handle of his surgical case was infected, the buttons of his coat, his pocket case as well; even his pockets and gloves and the lines with which he drove his horse were also infected. No wonder he had some cases that did not have a good "getting up," as the laity expresses it when a woman does not do well in labor. This gentleman scrubbed his hands carefully when he came to the confinement room; he used all the ordinary precautions to disinfect his hands, but could they be aseptic when everything he touched during the day was contaminated with the poison from the carbuncle?

You may ask, "What should he have done?" In the first place, the ideal manner would have been to have had some one else attend the carbuncle if it had been absolutely necessary to dress it at that time; failing this, it is never necessary to place the bare hands in pus. It is very easy to have a pair of forceps to pull the dressing away from an infected part. Take a piece of absorbent cotton in the same forceps and wipe away the pus, or use a syringe and have an attendant hold a basin to catch the water as it flows off the wound; cut the gauze with clean scissors and then bandage without coming in contact with the septic

* Read before the Camden City Medical Society, March 5, 1907.

material. The forceps which were used to take off the infected dressing can be thrown into a dish to boil, and by the time the dressing is completed will be sterilized, and the attendant can go on his way with his conscience clear that he has done his part for the patient without carrying the poison from him to his next charge. These precautions are much better if the attendant wears gloves which should be first washed on the hand in soap and water, then taken off by an attendant; as the surgeon infects the bare hand by taking off the second glove himself. The glove should immediately be placed in a vessel to boil, then kept in an antiseptic solution until the next visit. When a physician has several cases of this character, it is wise to have a pair of gloves in each house. By this means the surgeon's hands are always clean. Those persons who do the most surgery generally handle the least pus. By keeping the hands surgically clean, we develop what is known as the "Aseptic Conscience."

I think most of us have had the humiliating experience of attending puerperal fever cases. When I hear of a doctor having a case of puerperal fever, I think there has been some failure of aseptic precautions. Then the words of the Master come into my mind when they were going to stone the poor sinful woman, "Let him who is without sin cast the first stone." We have all been guilty of sins of omission and commission. Personally, I have lost four cases from puerperal fever since I have been in practice. I have always been careful to disinfect my hands in confinement cases, but not until recently have I realized the necessity of never getting them contaminated. In 1901 I attended a woman in labor; she had a normal delivery; on the fourth day she had a chill followed by a high fever; in a few days she began to discharge large quantities of pus from the uterus; her temperature ran very high, with a rapid pulse, for about six weeks, then it gradually declined and dropped to normal at the end of about ten weeks; several times during that period her temperature ran up to 106 degrees Fahr. She did not appear to be very sick; her mind was always clear, and she complained of no pain. She had some thickening of the tubes on the right side, and at one time I thought there was an abscess formation in the pelvis. This was never very clearly defined and it gradually disappeared. She eventually got well. This was a case of true puerperal septicaemia. About the second week of this woman's illness the nurse who

attended her told me she had just left a case in Philadelphia of like character which had proved fatal. After leaving my case she nursed her own daughter in confinement; the daughter became infected with puerperal fever and died. This old lady attended three women in succession with puerperal fever; the first occurred in Philadelphia under the care of a man of great experience—at one time a teacher of obstetrics—the second case occurred in my practice; the third under the care of a physician in the southern part of Philadelphia. The first woman died in the fourth week of her illness and the third woman on the fourteenth day. I believe this nurse carried infection from the first case to mine and from my case to the third. I gave her particular instructions to wash her hands with green soap and bichloride of mercury afterwards. The poison had evidently clung to her in spite of my precautions. This illustrates the point of always keeping the hands clean, and then, though we may be contaminated with the dust from the street, etc., we are not infected with pathogenic bacteria. This old woman had evidently not developed the "Aseptic Conscience."

In obstetrical work I believe the fountain syringe is responsible for a considerable number of cases of infection. It is a common practice for one woman to lend her syringe to another and often the nozzle is covered with secretions from the genitals which have been deposited there weeks or months before. It is the general practice to hang the syringe on the bedpost, and often the nozzle is picked up off the floor and passed into the vagina, covered with the dust from the carpet. Again, the poison is sometimes carried by the clothes placed against the vulva after labor. The average working nurse will put anything there to soak up the flow of blood. It has been my practice to wash off the vulva myself after labor. I used absorbent cotton and a solution of formaldehyde, taking small pledgets and cleansing the genitals, and finally placing a quantity of dry absorbent cotton over the vulva. It is said that the ingress of bacteria is retarded by absorbent cotton. Substances placed in bottles will resist putrefaction longer by plugging with absorbent cotton than with corks, showing that putrefactive bacteria will find their way around a cork quicker than through a wad of absorbent cotton.

I think that if the doctor's hands are surgically clean, he washes the vulva after labor and places absorbent cotton over the in-

troitus, he stands a good chance of escaping infection. It has been my habit to wear gloves in confinement cases for some time past. When I get a call for that purpose I immediately throw a pair of gloves into a sterilizer; I then place a new hand brush, green soap and formaldehyde solution in my obstetrical case; when the gloves are boiled, I turn them out of the sterilizer into a roll of sterilized gauze. When I arrive at the house I go to the bathroom, wash my hands in running water with green soap, then rinse them off in clean water, then through a solution of formaldehyde. The gloves are then dropped into a fresh formaldehyde solution, pulled on the hand, and I am ready to make the vaginal examination, with the feeling that I am not introducing the germs of disease. The instructions given to the nurse are: "Scrub your hands in soap and water, throw that solution out; wash your hands in creolin water, throw that solution out; take a fresh solution of creolin and sponge the genitals three or four times a day with sterilized cotton. In each case I leave a fresh hand brush for the nurse to use."

A short time ago, I saw the senior resident in a hospital in Philadelphia dress a case of appendicitis; the wound was foul and the case had been virulent. He dressed the wound with his bare hands and made no attempt to avoid contamination. He had assisted in two sections that day and might be called on any minute to assist in another. He told me the last ten cases in which he had assisted had suppurated. The inference was plain. No matter how carefully we may wash the skin, it is almost impossible to get it sterile; the micrococcus epidermis *Welchei* remains in the outer layers of the skin, and for this reason modern gynecologists have adopted the subcuticular stitch to close the abdominal wound, thus avoiding coming in contact with the last named organism.

In Noble's Clinic the "Aseptic Technique" is very rigorous. If a man comes in contact with a pus case he is unclean for forty-eight hours and can not assist in or perform an operation during that time. The junior resident dresses all the pus cases. On coming into the hospital, the surgeon removes his outer garments in the dressing room, a sterilized duck suit, outing shirt and muslin cap are donned; he is then in condition to enter the sacred precincts of the operating room. A clock stands in front of the sink and the surgeon must scrub his hands with sterilized water and green soap for twenty min-

utes; a sterilized pair of nail scissors are then used to clean and pare the nails. The hands are again gone over with soap and water and rinsed off. The next step is to go through the solutions—potassium permanganate, oxalic acid and formaldehyde. The second assistant places a sterilized towel over the clothing above and below the site of the operation. Four sterilized gauze pads are handed him by a nurse; she pours green soap on the abdomen; the assistant washes the part first with soap and water, then ether, alcohol and bichloride of mercury, taking a fresh pad to each solution. A copious flushing of the part with bichloride finishes the cleansing process. The same assistant then takes off the two towels which he had placed there. The first assistant then places two fresh towels in the same position as the soiled ones. A sterilized sheet is then placed over the clothing, both above and below the field of operation. A laparotomy sheet is then covered over all. The assistants then wash off their hands with sterilized water, go through the solutions and put on sterilized gloves. A nurse then hands a clean gown; the surgeon pulls the glove over the cuff of his gown, and then passes his glove through the solutions. He is then ready to proceed with the operation. With each case there is a change of gloves and gowns. The result of these elaborate preparations is that a very small percentage of wounds suppurate.

In conclusion I wish to state that since I have been cultivating the "Aseptic Conscience" I have had much less trouble in obstetrical work, and hope in future to reduce the mortality and morbidity which follow in the wake of septic conditions.

THE TREATMENT OF ERYSIPELAS: THE RESULT OF 71 CASES.*

By Palmer A. Potter, B. Sc., M. D.,
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In presenting a brief resumé of the result of the various treatments of this disease, I have no intention of bringing forward any new facts or theories as to the therapeutics, but hope simply to present the comparative results in my own experience, from which we may deduce the relative efficacy of any particular line of medication. The investi-

*Read before the Orange Practitioners' Society, April, 1907.

gation of all but three of those cases was carried on in the fall of 1899, when the writer was an interne in the New York City Hospital, one of the two institutions in New York to which cases of erysipelas are admitted, and covered a period of eight weeks.

The fact that erysipelas, particularly of the facial type, is, in fairly healthy people, a self-limited disease, and, after a more or less typical course tends spontaneously to recovery, makes it rather difficult to compare various methods of treatment. So in the majority of the uncomplicated facial cases, I used the regular stock treatment of ichthyol and collodion, or of chloral and camphor painted on the affected area. In the facial cases in people much run down, in the phlegmonous, in the cases of surgical erysipelas, and of the corporeal or ambulant type, and in one postpartum case, however, the tendency was but little, if at all, toward spontaneous recovery, and those afforded an opportunity and indication for the use of every recommended remedy, with the comparison of the results.

A considerable proportion of the cases were not admitted to the hospital until a day, and in some cases, two days, had elapsed after the initial chill, fever and facial blush, which offers yet another reason for the inaccuracy of definite statistical data. So, with your permission, I purpose giving a brief resumé of the treatments used with the general impression obtained at the time, of their comparative efficacy.

In thirty-seven cases, all of the ordinary butterfly facial type with no complications, I used a combination of camphor and chloral, one part of the latter to three of the former. The cases all recovered, and the local treatment did not appear to change in any way the course of the disease, except that the patients expressed relief at the coolness and quieting effects of the application. Internal medication in those cases, as in all the others unless otherwise specified, was merely symptomatic—a laxative febrifuge, occasionally dilute hydrochloric acid for the digestion, and hypnotics for the delirium that was an almost constant accompaniment, as most of the cases were in alcoholics. In ten cases I used the well-known ichthyol and collodion, and as all these were uncomplicated facial cases, they recovered in about the same time and ran the same average course as most of the others.

In the bad cases, that I shall take up more in detail, I tried many treatments, one after the other, in an endeavor to ascertain to

which one of the many they would respond. Among the most obstinate of these was a woman of 46, an alcoholic, no specific history, who came in with an ordinary attack of the facial type. I used chloral and camphor on her and expected her to get well in a few days. The face cleared up in due course and her fever fell from the initial high rise to about 102 degrees, near which it stayed until the final outcome. The tenderness that is so severe on top of the head persisted, and the red, raised and sharply defined border appeared on the back of the neck. Here I used carbolic acid, followed by alcohol, and later injection of a carbolic acid solution into the edge, and just beyond the edge, of the advancing border. The progress of the infection was not retarded and the constitutional symptoms persisted, although the temperature seldom went above 102.5, which is low for erysipelas. I then cut down to the cellular tissue just beyond the advancing edge and cauterized with pure carbolic acid, followed by alcohol, and at the same time injected antistreptococcus serum. A dirty slough was the only result of the local treatment, the disease still advancing. The woman finally became delirious and died, the edge of the infection having advanced by that time as far down the back as the iliac crest.

Another case upon which many forms of treatment were used was that of a man of 46, an alcoholic, very stout and plethoric. He had a Scheede operation for varicose veins done on him by a member of one of the surgical staffs, and a few days after developed erysipelas in one of his big toes. This rapidly extended, accompanied by severe constitutional symptoms and continuous delirium. The following measures were used: I first made pressure just beyond the advancing border by means of tightly applied lead plaster. As a control, a small opening was left for about one inch, and through this the erysipelas edge advanced, but was markedly delayed on the line of the constricting plaster. After this the plaster was put completely around the leg, but, though the advance was delayed, the infection nevertheless steadily progressed and the constitutional symptoms were not affected in the least. So in succession the following measures were tried: Ichthyol and collodion locally, and antistreptococcus serum and then ungt. Credé, but nothing influenced the extension of the local infection nor ameliorated the severe constitutional symptoms and the man finally died in delirium. In several of the facial cases—five, to be

exact—the old Hippocratic method of cold water applications was resorted to, with the result that they all got well, as did also five cases in which no treatment at all was given except an initial dose of calomel and occasionally a little dilute hydrochloric acid. And they recovered just about as quickly, easily and more comfortably than those in which heroic and disfiguring treatments were employed.

Another case in the list without the general tendency toward recovery was that of a woman recently delivered by a midwife, who was brought into the hospital with erysipelas on the vulva and extending down the thighs, but without the severe initial constitutional symptoms that might have been expected. It was quite difficult to differentiate the case from cellulitis, as her temperature did not go above 102.5 at any time, which is very low for an erysipelas of any severity. In this case, in addition to general supportive measures, I used ungt. Credé, antistreptococcus serum of the New York Health Board, and locally collodion and celloidin as a superficial compressor just beyond the advancing edge, wet bichloride dressings, ichthyol, and carbolic acid, none of which had any effect whatever upon the progress of the infection or upon the constitutional symptoms, the patient dying five days after admission.

Since the original compilation of the preceding list I have treated three cases of erysipelas with the red light—two facial and one on the upper arm. This was done, not with the idea that red light itself had any curative effect, but for the following reason: The short wave lengths are at the violet end of the spectrum, the ultraviolet, actinic or chemical rays being especially irritating to the skin, and if any light at all is to be used, those rays furthest removed from the violet—the red—must be employed.

If this method were to be used with an idea as to the strict tabulation of definite results, all light should be excluded and the patient kept in an absolutely dark and rayless room. Practically, however, the exclusion of the violet rays was obtained by means of red paper pasted on the windows and woodwork and laid over the bed. At the same time crape was fitted over the affected area with eyeholes, if on the face. In the first case, a woman 58 years old, facial erysipelas, one eye closed, nose typically affected, temperature on the first visit 104.6; after the red light was used the other half of the face showed no signs of invasion, and on the third day the tempera-

ture was only 99.4. The next case treated with red light was of a man 82 years old, with erysipelas on the right arm. It became phlegmonous, really more of a cellulitis than an erysipelas. Six incisions were made for drainage, but he got up a pneumonia and died in a short time. The red light had no influence on the course of the disease. In another case, a woman 39 years old, of facial type, the temperature on first visit was 104.8, the blush and border typical of facial erysipelas. Red light was used, but the temperature took four days to drop to normal.

If shutting out the ultraviolet rays in this, or in any other skin disease, is efficacious, why do negroes have irritation of the skin and desquamate after the exanthemata the same as whites, unless the inflammation of the skin is always superficial to the pigmented layer? Major Charles E. Woodruff, in a remarkably complete work on "The Effect of Tropical Light on White Men," shows that the negro only is fitted for permanent residence in the tropics because his pigmented skin and bushy hair shut out the ultraviolet rays of the tropical sunlight, which in the white man, failing those natural protectants, invariably affect the vital centres. The pigmented layer of the negro's skin is superficial to the lymphatic tissue, where occur the lesions of erysipelas. Why, then, is not the negro with this disease being treated with a permanent and almost impenetrable filter for sunlight? I am aware that the negro is supposed to seldom have erysipelas, but judging from my own experience, I think the belief is due to the extreme difficulty of diagnosis and not to his natural immunity. Two of the cases I have treated were in negroes, and another, a native of Brazil, appeared at least a mulatto. In all three the disease ran a course as severe as the average in white men, one especially having a severe attack, his temperature going to 105.5 with marked cerebral symptoms? Just a word as to the diagnosis in the negro. It has to be made practically on the chill, temperature and palpation, the induration and sharp raised border, as presented to the tip of the index finger being pathognomonic.

In all, there were seventy-one cases, treated as follows: Camphor and chloral (1-4), 37; antistreptococcus serum, 5; incision beyond edge of infection and carbolic acid applied, 1; strapping beyond edges, 4; plain cold water, 5; ichthyol and collodion, 10; collodion or celloidin beyond edges, 2; bichloride dressings (1-2000), 2; no local

treatment, 4; red light, 3.

Judging from the general results of the various treatments tried, the great majority of facial cases do about as well with the classical treatment of cold water or similar soothing application as with any other. In the few facial cases that tend to extend, and in the cases of surgical and ambulant erysipelas no one form of treatment, either local or constitutional, seemed to give results that would entitle it to be classed as preferable to all others. The treatment is expectant, the expectation being recovery. If the expectation does not give promise of being realized there is nothing except supportive measures that we can use to make that result more certain.

PRESIDENT'S ADDRESS BEFORE THE CAMDEN CITY MEDICAL SOCIETY.

By Henry H. Sherk, M. D., Camden, N. J.

I cannot retire from the chair of this Society without expressing to you and all of you my heartfelt thanks for the courtesy extended in electing me to preside over your deliberations during the past year. It has been a great pleasure to see the interest taken by the members who have gathered here from time to time at the shrine of Aesculapius to hear the reading and discussion of the various scientific papers brought before them. I trust that none have gone away without taking with them some little knowledge. The social features have been very pleasant and productive of good as we have listened to the remarks of our members and others who have gathered around the festive board. I have selected for my subject this evening,

"Some of the Things We Need."

The city of Camden has grown in the last decade to a city very nearly of the first class: it has left swaddling clothes and is something more than a child. It needs not and cannot exist on milk, but on meats and stronger food; that which sufficed ten years ago, will not answer now. The City Society has done grand work in the past, for by its constant agitation and endeavor it has secured to our city one of earth's greatest blessings, namely, one of the best water supplies in the world, which has given to our beloved city the lowest death rate of any city of its size in the United States, banished typhoid fever from its precincts, added greatly to its wealth and prosperity, and made it desirable as a habitation for thou-

sands who appreciate good health and pure water. The Camden City Medical Society has always been foremost in advocating municipal improvements of a hygienic character. Can we not now join hands in a demand for that which is one of our greatest needs—a municipal hospital, a refuge for the proper care of our contagious diseases, particularly those we have ever present with us, diphtheria and scarlet fever? Every one knows how difficult it is to treat these diseases, especially in the poorer classes which come under our care. I believe many lives could be saved by the proper care of these cases. In a city of the population and resources of Camden there should be no difficulty in procuring a sufficient appropriation for the establishment and maintenance of a hospital that would be worthy of the name. The people and the profession do not want a pest house.

Fees for the Examination of the Indigent Insane. That the physician should be adequately paid for his services is an undisputed fact; this should be especially true in the examination of the indigent insane. The price now paid (\$3.00) is an insult to the profession, and as long as the fee is so small we cannot give our best services to the cause. Do we not sell our valuable services too cheaply?

Fees for Testimony in Court Cases. Nearly all of us have been subpoenaed as witnesses in court to testify in some accident case, and been compelled to wait from hour to hour and sometimes forced to lose a whole day (the mills of the law grind slowly) for the munificent sum of fifty cents, but the lawyers pocket their hundred dollars. In many cases without our testimony they would not receive one cent. Is it not fair to demand that when we are wanted in such cases, we should be sufficiently remunerated for our services?

The Nurse Question. The trained nurse is an angel of mercy, a true blessing and a great benefit to those who can afford to employ her, but in a vast majority of cases an expensive luxury to those whom we have always with us—the poor. Administering and bestowing her benedictions on the more fortunate ones who can pay for her services, assisting the physician to a remarkable degree, she cheats the grim monster of many a victim. Too much praise cannot be given her for her self-sacrificing labors. We feel doubly secure when she stands by our side in our ministrations to the sick. We know that when we cannot be at the bedside of our patient, she is there for us, relieving us

of the responsibility that we would otherwise bear. But what are we to do with those who are less fortunate, who are not able to procure the trained nurse and who must needs have some one who has not the proper training or experience? The nurse who lives around the corner, perhaps some widow or the type of nurse familiar to us all offers her services from \$5.00 to \$7.00 per week, but she knows nothing of hygiene or the laws governing asepsis.

We have now in our city three public libraries with suitable auditoriums. Would it not be a grateful act in behalf of our Society to give occasional talks, say one or two a month, and invite those who would care to hear discourses on the general principles of nursing. We who attend those who cannot afford to employ the trained nurse know how seriously we are handicapped in our dealings with patients through the limited knowledge of the incompetent. I would suggest that this Society take some action on this important question, and that the chair be empowered to appoint a committee whose duty it shall be to formulate some plan of action, so that those nurses who have not had advantages of training may at least learn the value of some of the vital principles governing proper nursing. I have reason to believe that many of our septic cases are made so by the unclean nurse. These popular talks would enlighten them as to the important value of cleanliness, also the responsibility of attending the sick. The scripture says, "To him that knoweth the truth, and doeth it not, to him it is sin." I do not think that there would be any trouble in procuring an audience to listen to these talks, but think that the laity is ready for such service. Again, I think this work will be much appreciated and that we as physicians will be well repaid for the time we give to this cause, and that the great mass of patients whom we attend would be greatly benefited.

Our Office Work. We need to give more time to our office patients. We need to make closer examinations, not merely a casual observation—as feeling the pulse, looking at the tongue, and percussing or palpating the chest. The question before us is, can we afford to do it for fifty cents? There are many who come to our offices with slight ailments, but there are others who have hidden symptoms which if they were properly diagnosed would shed rays of light on some serious malady, and thus save us from chagrin by having some other physician make a proper diagnosis. We, who

are the older members of the profession, must look to our laurels and make every effort to keep abreast of the times. By becoming acquainted with the newer methods of diagnosis and the instruments of precision that are of so much account in making correct diagnoses. If a patient consults a specialist in one or more diseases he will pay him from \$5.00 to \$25.00 for an office visit, while we are content to receive from fifty cents to a dollar. Do we not value our services too cheaply? That we should not do. A cheap medical man is not wanted at any price, and the public respect a dollar man more than they do a fifty cent one. Let us give our patients the best we have and charge them for it and they will soon have a higher appreciation of us.

We need a more Christian spirit in our dealings with men. Success does not depend on the accumulation of dollars and cents per se, but on the rounding out of a true and honorable life. We must all live; we all want enough to educate our sons and daughters and perchance lay enough aside as a competence for old age. What is more grand and more noble than character? It cannot be purchased with lucre; it is more to be desired than riches. When it is once destroyed it takes a whole life to restore it. To my mind there is no being more respected on earth, more honored by men and admired by angels than the clean, upright, conscientious physician. Where will you see more genuine tears, more true sorrow, more unstinted praise than at the bier of the beloved physician, whose body is about to be taken to its last resting place? Take away your gold if it is gotten from questionable sources, if it come with the stain of human depravity, if it come from robbing the widow and orphan of the necessities of life. The world is full of policy men, men who do good when it is to their own advantage, but who forsake principle when it is to their advantage to do so. Principle stands on its own bottom, can always be depended upon, is always constant, does not lie, is honored by God and men alike. These days demand men of principle in and out of the profession. As Doctor Holland so aptly says:—
"God give us men: times like these demand
Strong minds, great hearts, true faith and
real hands.

Men whom the lust of office does not kill,
Men whom the lust of office cannot buy,
Men who possess opinions and a will,
Men who have honor, men who will not
lie,
Men who can stand before a demagogue

And down his treacherous flatteries without winking.

Tall men: suncrowned men, who live above the clouds,

In public duty and in private thinking.

For while the rabble with their thumb-worn creeds,

Their large profession and their little deeds

Mingle in selfish strife. Lo! freedom weeps;

Wrong rules the land, and waiting justice sleeps."

Reports From County Societies.

ESSEX COUNTY.

Frank Wilcox Pinneo, M. D., Reporter.

The annual meeting of the Essex County Medical Society was held Tuesday evening, April 2, 1907, at Oraton Hall, Newark, 214 members registering as in attendance. The President, Dr. Archibald Mercer, presided. The minutes of the last annual meeting were read by the Secretary, Dr. R. H. Hunt, and approved. The Treasurer, Dr. C. D. Bennett, made his report, showing the need of \$4 from each member as dues for 1907. Dr. H. B. Vail was appointed on the Necrology Committee, vice Dr. D. M. Skinner, deceased. For this committee Dr. Charles Young, chairman, reported the death of Dr. Charles Rulon Pettinger, Dr. Daniel Moore Skinner and Dr. Matthew Thomas Gaffney. Obituary notices of them have already been published (See this Journal August, 1905; May, 1906, and November, 1906).

During the year the following scientific meetings were held: February 1, Dr. J. N. McCormack spoke, representing the A. M. A.; February 19 Dr. J. H. Musser presented the subject of "Pancrreatitis"; March 19 Dr. Andrew J. McCosh lectured on "Acute Gastric Hemorrhage"; January 15 Dr. William M. Polk had arranged to speak, but was prevented by illness, and the meeting was called off the last day.

The two committees on Scientific Meetings and on Revision of By-Laws jointly reported on the matter of special committee's report, referred to them, favoring ten scientific meetings yearly, with one-half hour only for business at each, that they had no recommendation to make.

Among the articles of the By-Laws revised the most important was that on membership: "Any practitioner of medicine of approved moral and professional reputation, who holds the degree of M. D. from the Medical Society of New Jersey or a reputable medical college, and who has conformed to the laws of this State regulating the practice of medicine and to the rules of the Medical Society of New Jersey, shall be eligible to membership in this Society."

The Council nominated fourteen new members, all of whom were elected. A resolution was introduced, and passed with unanimous approval, commending the sturdy and successful fight by Dr. Albert Wickman against a malpractice suit, with its blackmail, and praising the fraternal spirit of several practitioners who aided him with their generously given testimony.

The Council reported receipt of a communication from the State Society and their reply on the following items: (1) Concerning public meetings, they thought we already were covering the ground by the scientific meetings now held; (2) the exchange of papers between component societies, they approved; (3) courses of medical lectures and clinical meetings of a post-graduate kind, they did not recommend; (4) on contract work, no further action because of an adequate resolution passed a year ago; (5) on insurance fees, approval of the State Society's resolution; (6) a roll of all registered practitioners in the county, the Secretary has already had made for the American Medical Association directory.

The Committee on Public Health, appointed last year, made no report. A resolution against the bill in the Legislature licensing osteopaths to practice medicine was carried. The revision of fee table was referred to the Committee on By-Laws. A resolution, introduced by Dr. W. J. Chandler, against current insurance fees, was laid on the table. This, it was remarked, not because of approval of the present low fee schedule of some companies, but because the resolution "read out of membership" any one accepting the low fee.

The President made his address on some of the manifold faults in matters of public health, reviewing his long connection with the Society as an officer and the increasing needs of public hygiene. It was ordered printed.

The following were appointed delegates to the State convention: Doctors Disbrow, Bradshaw, Clark, Cook, Condon, Becker, Davenport, Emerson, Eagleton and Epstein. A resolution was carried making the Medical Library Association of Newark, N. J., custodian of certain volumes of books.

The following were elected officers for the new year: President, Dr. Herman C. Bleyle; Vice-President, Dr. Wells P. Eagleton; Secretary, Dr. Ralph H. Hunt; Treasurer, Dr. Charles D. Bennett; Reporter, Dr. Frank W. Pinneo; Councilors—Three years, Dr. Samuel E. Robertson, Dr. Frederick C. Webner; two years, Dr. Charles Young.

HUNTERDON COUNTY.

Leon T. Salmon, M. D., Reporter.

Three meetings of this Society have been held this year, two regular meetings and a special, the latter held for the lectures of Dr. J. N. McCormack. At the fall meeting, in addition to an interesting paper by Dr. T. B. Fulper, on "Malarial Fever," a very helpful discussion of obstetrical cases was engaged in. From the nature and manifest interest in this discussion, it appeared to the writer that this was the method most desirable to make our Society meetings interesting and helpful. In the regular course of business a resolution was passed fixing five dollars as the minimum fee for medical insurance examinations for amounts of one thousand dollars or more. An invitation was extended to Dr. McCormack to visit us and deliver his lectures. On February 13, Dr. McCormack came to Flemington and in the morning spoke to the members of the Society and in the afternoon spoke to a meeting of citizens. Both lectures were of unusual interest and can not but be of great benefit to the profession and the public.

On the 23d of April the spring meeting of the Society was held and an attempt was made to

infuse into the work the spirit of the lectures given before the Society by Dr. McCormack. One paper was read upon the anatomy of the kidney and another upon the pathology of it; the third paper expected was not presented. Dr. W. A. Clark, the Counsellor, was present and made a short talk. Dr. M. H. Leaver reported a case of pneumonia with phlebitis as a complication and Dr. E. D. Leidy reported a case of diabetes and pruritis. The question of adopting the plan suggested by Dr. McCormack was then taken up and, after considerable discussion it was decided that it should not be adopted. The apparent disloyalty in this decision has its explanation in the fact that our membership is, in contradistinction to the membership of the city Societies, scattered over a large county and that the facilities for transportation are extraordinarily poor. It was decided that a modified plan should be adopted, and to this end a committee was appointed to formulate such a plan and to report at our next regular meeting. It was also decided that the frequency of meetings could not be increased, but it was the voice of the Society that the McCormack plan was the ideal one that should be adopted where possible. A feeling of regret was shown by a large minority, and even among the majority it was evident that we felt keenly our inability to follow such a well-organized plan in carrying out the work of the Society as the McCormack plan afforded.

We are grieved to report the death of Dr. G. W. Bartow, of Three Bridges, N. J., who was a much respected and able physician.

During the year, while the general health of the communities in this county has not been good, there have been no epidemics excepting local ones.

We deplore the low percentage of resident physicians who affiliate themselves with this Society and make mention of it here, that the members of this Society who shall see this will take it upon themselves to make the effort to induce non-member physicians to avail themselves of the opportunity to associate.

Lambertville, N. J., April 29, 1907.

SALEM COUNTY.

John F. Smith, M. D., Reporter.

The annual meeting of the Salem County Medical Society was held Wednesday afternoon last at the Schaefer House, this city. The meeting was an interesting one and was largely attended, several visitors of note being present with the county physicians.

Among the visitors were Surgeon Charles P. Noble, of Philadelphia; Drs. George A. Reading and H. A. Wilson, of Woodbury. Dr. S. B. Harris read a very interesting paper on "Pneumonia." Dr. William T. Hilliard was elected a member of the Society.

The physicians reported that there is no epidemic of contagious diseases in the county and especially in Salem, except whooping cough. The meeting being the annual one, the election of officers was held and resulted in the following being elected for the ensuing year:

President, Nathaniel S. Hires, Salem; Vice-President, Lester H. Hummer, Salem; Secretary and Treasurer, Henry Chavanne, Salem; Reporter, John F. Smith, Salem; Delegate to the State Society meeting in June, Warren L. Ewen, Alloway.

A banquet was served after the meeting.

WARREN COUNTY.

John H. Griffith, Reporter.

The annual meeting of the Warren County Medical Society was held at the Warren House, Belvidere, on Tuesday, May 21, 1907. The attendance of members and applications for membership exceeded all previous records. The fraternity banquet was again an enjoyable feature. During the business session several subjects of vital importance to the Society were discussed at length, after which the following officers were elected for the ensuing year:

President, Thomas S. Dedrick, of Washington; Vice-President, Dr. Edward H. Moore, of Asbury; Secretary, William J. Burd, of Belvidere; Treasurer, George W. Cummins, of Belvidere; Reporter, John H. Griffith, of Phillipsburg; Delegates to State Convention, L. C. Osmun, of Hackensack; Censors, J. C. Johnson, of Blairstown; F. J. LaRiew, and C. M. Williams, of Washington; Committee on Legislation, C. B. Smith, of Washington.

By the way, Dr. Johnson, of Blairstown, was present as usual, and was observed to bear his years, which are now nearly eighty, with his usual grace. He is not only the veteran of the medical fraternity of Warren county, but perhaps the oldest living, active practitioner in the State. Dr. Johnson has a record of fifty-seven years of continuous practice to his account. If we are not mistaken, Dr. Johnson has served all these years as practitioner at Blairstown and surrounding country.

NEW MEMBERS OF THE AMERICAN MEDICAL ASSOCIATION FROM NEW JERSEY.

Campbell, W. K., Long Branch.
Cory, Horace C., Newark.
Duncan, Owsley B., Haledon.
Gordon, Altamont L., Burlington.
Kuehne, Richard, Jersey City.
Maclay, Joseph A., Paterson.
Ridgeway, William F., Atlantic City.
Van Dyke, Joseph S., Hackensack.

NEW MEMBERS OF OUR COUNTY MEDICAL SOCIETIES.

Camden.—Charles Braddock, Camden.
Cape May.—Margaret Mace, Anglesea; H. H. Tomlin, Wildwood; D. King Webster, Cape May Court House.
Cumberland.—Irving E. Charlesworth, Bridgeton; Millard F. Sewell, Bridgeton.
Essex.—Guiseppe Albano, Newark; Anthony M. Bacevycze, Newark; Hayes Joseph Burnett, Montclair; Charles W. Buvinger, East Orange; Edward Martin Colie, East Orange; Herman Cohn, Newark; Dundas Ralph Campbell, Newark; Max A. Maas, Newark; Gideon Howard Palmer, Newark; William Walter Rose, Newark; Alfred Stahl, Newark; L. Mancusi-Ungaro, Newark; Henry Rudolph Widmer, Newark.
Middlesex.—Bartholomew M. Howley, New Brunswick.
Monmouth.—Elmer A. Scott, Asbury Park.
Salem.—Charles Duffell, Salem; William T. Hilliard, Salem.
Somerset.—Elizabeth R. Graff, Somerville; C. F. Halstead, Somerville.
Camden County.—J. Alonzo Beck, Gloucester; Frank B. Cook, Laurel Springs; George W. Henry, Camden; Charles H. Jennings, Merchantville; Gerhard Loeling, Pensauken; William C. Raughley, Berlin; Joseph E. Roberts, Camden.

THE JOURNAL

OF THE

Medical Society of New Jersey.

JUNE, 1907.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any one failing to get the paper promptly will confer a favor upon the Publication Committee by notifying them of the fact.

All communications relating to the JOURNAL should be addressed to the Committee on Publication, 95 Essex Avenue, Orange, N. J.

CHANGE OF PLACE OF OUR ANNUAL MEETING.

FROM CAPE MAY TO LONG BRANCH.

There will doubtless be disappointment on the part of some of our members that the place of meeting of our State Society has been changed from Cape May to Long Branch. It was, however, necessary, as the new and luxuriously planned hotel which invited us will not be sufficiently near completion to make our visit there this year as enjoyable to our members as we had expected, or as satisfactory as we and the hotel management would desire; nor have the extensive harbor improvement by our national government been more than begun. Then we believe the change is decidedly best for this year's annual meeting, because the American Medical Association meets during the same month at Atlantic City. Many of our members from the northern part of the State will attend the latter and probably would not go again to the same vicinity to attend our meeting.

Meeting in the central portion at one of our most popular seaside resorts will doubtless, under these circumstances, give us a much larger attendance than we would have had at Cape May. So let us expect and plan for a larger meeting than usual. The excellent program, and the central location, warrant optimistic expectations.

WELCOME TO THE A. M. A.

We extend a most hearty welcome to the members of the American Medical Association who will gather again in annual meeting in our State June 4-7th, at Long Branch. We are pleased that they enjoyed their visit among us so much in 1904 and were so captivated by the grand old ocean and popular city by the sea that they will return to us in even larger numbers than before. The programs for the various Sections of the Association give promise of a very interesting and profitable meeting.

PROGRESS IN THE PRACTICE OF SURGERY AND GYNECOLOGY.

That we are living in a period of wonderful progress in the various branches of our profession's activities is unquestionable, and because of that fact it becomes the scientific practitioner to weigh well his utterances and his actions, for in both, undue haste and carelessness that lead to unjust criticism and faulty judgment, is decidedly unscientific and tends to retard progress. Accuracy of statement and correct deductions from clearly established facts are essential. There are no branches of practice in which this is more true than in those of surgery and gynecology.

There is little doubt that a few years ago there was a tendency to hasty decision and unnecessary operations when many young women were unjustifiably mutilated by the removal of their uterine appendages—unnecessary because they were free from disease. Many non-diseased appendices were also removed when operations on other organs in the abdominal cavity which were diseased were performed. We believe these latter removals were unjustifiable from our conviction that the appendix has some beneficial function to perform, though we do not yet know exactly what it is, otherwise its existence would be exceptional.

But we believe that the tendency to-day is to exercise far more care and judgment—in other words, to be more scientific—in operating, and that the aims of the surgery

of to-day are to preserve structure rather than to mutilate or destroy it, so that we are inclined to question the statement in an article in another column that—"To-day it seems to be all important to know *how* to operate, instead of—as in the times of Bill-roth and Gross—the essence of surgical education was the knowledge of *when* and *why* to operate." We, however, agree with the writer when he says:—"The physiological therapist has a well-equipped armamentarium to choose from before he resorts to the knife. Mechanical skill should not be the end and purpose of surgical education, but always be the means to the end." We believe that the able, conscientious surgeons and gynecologists also endorse this statement and are to-day acting in accordance therewith, and as a result many thousands of lives are not only being saved, but are also thus enabled to fulfil the purposes for which their beneficent Creator gave them being.

Do not forget the change of place of our annual meeting from Cape May to Long Branch, and the time—June 25-27, 1907. Arrange your business so that you can attend. Bring the ladies of your family.

THE APPOINTMENT OF MEDICAL MEN IN OUR STATE INSTITUTIONS

We cannot speak too highly of the work which New Jersey has done for the care and relief of the sick, suffering, insane and other classes of our citizens who are in need, nor of what we might properly characterize as the greatest work—that of saving a far greater number from contracting disease and becoming wards or beneficiaries of the State. And, with just and proper pride, we observe that it has been the chief—the crowning—glory of the Medical Society of New Jersey that this work has been undertaken after, and because of, the persistent advocacy and efforts of its members. Nearly every institution established for the relief of the unfortunate has had its origin in the suggestions and agitation made in the meetings of our Society, and most of them

after years of earnest entreaty with our legislators. We cannot now enter upon a detailed account of these various efforts and will mention only our State Hospitals for the Insane, State Board of Health, Epileptic Colony and Tuberculosis Sanatorium. Nor can we refer to their enormous value to the State and the wonderful blessings they have bestowed upon our afflicted citizens, especially of the indigent class; or what the last named—Sanatorium—gives promise of bestowing when completed and properly managed.

We believe that in the main these institutions have been well officered and managed, but we call the special attention of the members of the Medical Society of New Jersey to the vast importance of zealously watching and guarding the administration of these sacred trusts, especially in reference to the medical men who are charged with tremendous responsibilities in the conduct of these institutions. Not only should men of decided ability and experience be selected, but the selection should be entirely free from all political manipulation and all favoritism. To do otherwise is to be unfaithful to the State, untrue to the medical profession and criminal toward the unfortunates who deserve and should receive the best possible care and treatment.

We call special attention to this because of the action of our Society at the last annual meeting, authorizing the Board of Trustees to present to the Governor the names of capable medical men from which to make choice for the various positions to be held by medical men. The Board of Trustees we believe wisely deferred action until further discussion is had at the approaching annual meeting, as to the best course to pursue. We should do something towards keeping these positions free from political manipulation and securing thoroughly competent and experienced men. They should be men who will not use these positions to further their own interests, but whose highest ambition will be to make these institutions equal if not superior to any in the land in efficiency and results, for

the credit of the State, the reputation of these institutions and the greatest good of their inmates primarily, and indirectly for maintaining the good name and honor of our profession.

We urge those who have the interests of these institutions and their unfortunate inmates at heart, who as Jerseymen and medical men are not indifferent to the honor of the State and of our profession, and who expect to attend the approaching annual meeting of our State Society, to give this subject their best thought and come prepared to act as its importance demands. Again we say that our Society, having taken the initiative in the organization of these State institutions we *ought* not, *we must* not be indifferent to their proper management, and we have a right to insist on the appointment from the ranks of our profession such men as we have suggested that we may have the highest efficiency and secure the best results from these institutions.

As important business is always transacted by the House of Delegates, every delegate should be present; if any cannot attend, see that your alternate is present.

LOOKING BACKWARD!

This—June—issue of the JOURNAL closes the third year of its existence and we are glad to know that whereas this work was begun three years ago with misgivings on the part of many of our State Society members and some opposition, that the JOURNAL has been growing in favor and that the wisdom of the decision then made is to-day not only recognized by our membership generally, but that the majority of the State Societies in our country are now publishing their monthly journals and are convinced of the necessity of maintaining them because of the decided advantages of the JOURNAL as compared with the old volume of transactions.

During the past year we have endeavored to maintain the high character and reputa-

tion of our JOURNAL, and yet we are compelled to say that it has not yet come up to our ideal of what such a journal, representing the Medical Society of New Jersey—the oldest in the land, ought to be. While we may attribute this in large measure to our inexperience—it having been *our* first year of service, we have had to contend with some unusual obstacles, notably those incident to the strike in the printing office from which our JOURNAL is issued and which for three months made our work burdensome and difficult. We are glad to announce that the differences there have been wisely adjusted and that the publisher will be thereby enabled to serve us better than ever.

We have not yet obtained that closeness of touch with our County Societies and hearty coöperation of their representatives—the Secretaries and Reporters—which we desire, for the highest advantage, not of the JOURNAL only or primarily, but of the members of our profession throughout the country: for by our thirty exchanges with the official State journals and independent medical journals, our JOURNAL goes monthly into all of the States of our Union; so that the members of the profession in our State, and the good work they are doing, are known as they never were when recorded in the yearly volume of "Transactions."

The editor closes the year's work thanking the Publication Committee, the Secretaries and Reporters of the County Societies and all others who have assisted in the endeavor to make this JOURNAL truly and faithfully to represent the work of our State and County Societies.

The index of Volume III will be issued with the July number of the JOURNAL.

An important meeting of the Board of Trustees of the Medical Society of New Jersey will be held in the Hotel Scarboro, Long Branch, on Monday evening, June 24th, at 8.30 o'clock sharp. The presence of every member is requested.

STATE ANTI-TUBERCULOSIS ASSOCIATION.

The first annual meeting of the New Jersey Association for the Prevention and Relief of Tuberculosis was held in the Free Public Library building, Newark, May 22, 1907, President Van Wagenen in the chair. The reports of the president, treasurer and executive secretary—W. C. Smallwood, were read, showing a year of remarkable activity and results. The last named report will be found on another page of this JOURNAL. Ten new directors were chosen for the five year term and one to fill vacancy for four years, among them Drs. William Elmer, N. L. Wilson, J. E. Gluckman and H. P. McAlpin—members of the Medical Society of New Jersey, as are also the president, Dr. G. K. Dickinson, of Jersey City; vice-president, Dr. W. G. Schauffler, of Lakewood, and, as members of the executive committee, Drs. T. W. Corwin, of Newark, and W. H. Murray, of Plainfield. Fred E. Clerk, of Newark, was elected secretary and treasurer. Dr. Lawrence F. Flick, of Philadelphia, gave an exceedingly interesting and instructive address on "The Prevention of Tuberculosis," which we believe would stimulate greater public interest and activity in this important campaign against "the great white plague" if it should be delivered in the principle cities of our State.

This Association is to be congratulated on the good work already done, on the officers selected to lead, and on the encouraging prospects of greater success.

TO COMBAT THE PLAGUE.

The Japanese government has announced its intention of accepting President Roosevelt's proposal for the holding of an international conference at Tokio to consider measures for stamping out the plague.

CONFERENCE OF MILK COMMISSIONS.

The Medical Milk Commissions in the United States will hold a conference at the St. Charles Hotel, Atlantic City, N. J., on Monday, June 3, 1907. There will be three sessions—10 A. M., 3 and 8 P. M. The main objects of the conference are to determine the scope of the Medical Milk Commission, harmonize its working methods and requirements, and establish uniform standards for "certified milk." It is expected that a permanent organization will be effected. Among the medical men who sign the call for this conference are two permanent delegates of the Medical Society of New Jersey—Henry L. Coit, M. D., Temporary Chairman, of Newark, and Thomas W. Harvey, M. D., of Orange.

THE ONE HUNDRED AND FORTY-FIRST ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

WILL BE HELD AT THE
HOTEL SCARBORO, LONG BRANCH

ON THE
25th, 26th and 27th of June, 1907.

The Committee on Arrangements announces that the One Hundred and Forty-first Annual Meeting of the Society will be held at the Hotel Scarboro, Long Branch.

All arrangements for the entertainment of the Society at the magnificent new Hotel Cape May (at Cape May) had been completed when, on May 18th, the proprietor of the hotel notified the Society that, owing to a strike of mechanics, the hotel would not be finished in time for the meeting. The Trustees have decided to hold the Annual Meeting at the Hotel Scarboro in Long Branch. The management have been good enough to offer a special rate of \$3.00 per day for the session. While the plans of entertainment have been disarranged, and we are not yet in position to make definite announcements, the Committee has promise of a number of attractive diversions for all the members and guests in attendance.

PAUL M. MECRAY, Chairman.

The Scarboro Hotel is located at the corner of Ocean and Bath avenues, in one of the most delightful sections of Long Branch. It faces the ocean, and is in close proximity to two other large hotels. A new board walk, two miles long, has recently been put down along the beach front. The hotel is two blocks directly east from the New York and Long Branch Railroad, and one block from the New Jersey Southern, which latter road has a station at Bath avenue. Persons coming by way of New York can take the boat to Sandy Hook and thence by rail to Bath avenue station, which is about five hundred feet from the hotel.

ANNOUNCEMENTS.

The Committee on Credentials will meet in the Hotel Cape May at 10 o'clock A. M., on Tuesday, June 25th, to examine certificates of membership, and to open the registration book. It is required that all fellows, officers and members register therein. Permanent delegates failing to register are considered as absent.

All annual delegates are required to present their certificates before they can be accepted as members. All annual delegates of the Medical Society of New Jersey shall produce a certificate of election at each annual meeting, signed by the president and secretary of the component society which they respectively represent; and no annual delegate will be permitted to sit as a member of the house of delegates without said certificate, nor unless the component society from which he is a delegate shall have paid its annual assessment. When the right to membership has been verified by the committee on credentials, the member shall receive a certificate or badge. No member or delegate shall be permitted to take part in any of the proceedings until he has registered nor until all the provisions of By-Laws, Chap. I, have been satisfied.

All members of county societies in good standing are entitled to seats as associate delegates, and when they report themselves to the Committee on Credentials their names will be entered on the roll.

The author of each paper before or immediately after its presentation, is required to deliver a copy of the same to the Recording Secretary. The expense of alterations of a paper after it is in type, as well as the cost of engravings and diagrams is borne by the author.

The attention of readers of papers and reports is especially called to the prescribed time limit of twenty minutes. (By-Laws, Chap. III, Sec. 4.) In the general discussion of these papers, all speakers (except those appointed to open the discussion) are limited to five minutes each.

All papers presented in this program take precedence over those subsequently offered, and will be read, as nearly as possible, in the order herein announced.

Members desiring to present voluntary papers or reports of cases should apply early to the Committee on Program.

Each delegation is requested to report to the Recording Secretary as early as possible the name of its member to serve on the Nominating Committee.

The Nominating Committee will meet at 5 P. M. on Tuesday, June 25th.

Certificates of nominees for permanent delegates should be sent to the Recording Secretary on or before June 15th.

First Day—Tuesday, June 25th.

MEETING OF THE HOUSE OF DELEGATES.

MORNING SESSION 10.30 O'CLOCK.

1. Calling the meeting to order.
2. Report of the Committee on Credentials, Daniel Strock, Chairman.

3. Reading of the minutes of the last annual meeting.
4. Report of the Committee on Arrangements, Paul M. McCray, Chairman.
5. Election of Permanent Delegates.
6. Announcement of Committees by the President.
7. Report of the Committee on Honorary Membership, H. Genet Taylor, Chairman.
8. Report of Committee on Business, J. P. Hecht, Chairman.
9. Introduction of business requiring early attention.
10. Report of Committee on Program, W. J. Chandler, Chairman.
11. Report of Committee on Scientific Work, N. L. Wilson, Chairman.
12. Report of Committee on Publication, W. J. Chandler, Chairman.
13. Report of the Judicial Council, Philip Marvel, Chairman.
14. Report of the Corresponding Secretary.
15. Report of delegates to and reception of delegates from other societies.
16. Report of Special Committees.
17. Report of Committee on Prize Essay.

Immediately after the adjournment of the morning session, the delegations from the different county societies are to meet to select their respective members for the nominating committee. Each member elect should present his certificate to the Recording Secretary before the opening of the afternoon session.

First Day—Tuesday, June 25th.

MEETING OF THE HOUSE OF DELEGATES.

AFTERNOON SESSION, 3 O'CLOCK.

1. Invocation.
2. Address of welcome.
3. Announcement of the names of the Nominating Committee.
4. Report of the Recording Secretary.
5. Report of the Treasurer.
6. Report of the Board of Trustees.
7. Miscellaneous business.

General Session.

Some remarks on the Lymphatics. E. Zeh Hawks, Newark.
Synopsis. Physiology and pathology of lymph absorption in general. Pathological and surgical importance of knowledge of the distribution of the lymphatics. Their anastomotic relations. Their life history.

Discussion opened by Charles Young, Newark.
Otitic pyemia without mastoid involvement. W. P. Eagleton, Newark.

Synopsis. The over value by the general practitioner of the absence of mastoid tenderness, irrespective of the supuration being acute or chronic. Frequency of the condition chiefly in infants and in chronic suppurative cases. Anatomical reasons. Points in diagnosis. The value of aural examinations, chills, temperature, enlarged lymphatics and blood examinations. Treatment.

Discussion opened by F. C. Ard, Plainfield.
The legality of state medical examinations and reciprocity in inter-state medical licensure. E. L. B. Godfrey, Camden.

Synopsis. Medical legislation in New Jersey. The police power of a state. The rights of a federal government, the state and the physician in respect to medical practice. Reciprocity in inter-state medical licensure. Its legality, limitations and methods of execution in New Jersey.

Discussion by John J. Baumann and Wm. Perry Watson, Jersey City.

First Day—Tuesday, June 25th.

General Session

EVENING SESSION—8 P. M.

Oration in Surgery—Some observations on four decades of American Surgery. Albert VanderVeer, Albany, N. Y.

Oration in Medicine—The Physician and the Medical Press. Morris Manges, New York City.
When and when not to operate in ruptured ectopic pregnancy. J. S. Baer, Camden.

Discussion opened by B. F. Baer, Philadelphia.

Second Day—Wednesday, June 26th.

General Session.

MORNING SESSION, 9 A. M.

Premature detachment of the placenta. J. W. Martindale, Camden.

Discussion opened by Henry H. Sherck, Camden.

SYMPOSIUM ON DISEASES OF THE GALL BLADDER.

Etiology and pathology. H. G. Norton, Trenton.

Diagnosis. P. A. Harris, Paterson.

Complications. G. K. Dickinson, Jersey City.

Medical treatment. J. H. Musser, Philadelphia.

Surgical treatment. John B. Deaver, Philadelphia.

Discussion opened by E. W. Hedges, Plainfield.

Tetanus and anti-tetanic serum. Daniel Strock, Camden.
The significance of blood pressure in surgical shock. A. J. Walschied, Hoboken.

Synopsis. New theories in surgical shock. Experimental cases. Observance of the blood pressure during shock.

Discussion opened by J. M. Rector, Jersey City.

Second Day—Wednesday, June 26th.

AFTERNOON SESSION, 3 O'CLOCK.

MEETING OF THE HOUSE OF DELEGATES.

Report of the Nominating Committee.

Election of Officers.

Report of the Committee on Hygiene and Legislation, L. M. Halsey, Chairman.

Report of Committee on Medical Defense, Wm. G. Schauffer, Chairman.

General Session.

1. Annual address by the President, Alexander Marcy, Jr., Riverton. "The Relations, Responsibilities and Duties of the Medical Profession."

2. Annual address by the Third Vice-President, B. A. Waddington, Salem. "Toxins and Antitoxins." How far may the general practitioner employ and benefit from laboratory methods of diagnosis. Robert N. Willson, Philadelphia.

Discussion opened by Alexander Marcy, Jr., Riverton.

Wednesday Evening, 8:30 to 11 P. M.

Entertainment at the hotel, under the charge of the Committee of Arrangements.

Third Day—Thursday, June 27th.

General Session.

GENERAL SESSION, 9 A. M.

Myasthenia Gravis. C. L. Lindley, Lakewood.

SYMPOSIUM ON THE ERUPTIVE DISEASES.

1. Scarlet Fever. Hiram Williams, Passaic.

2. Measles. Philip Marvel, Atlantic City.

3. Roethlin. Alexander McAlister, Camden.

4. Smallpox. E. E. Worl, Newark.

Discussion opened by Henry J. F. Wallhauser, Newark.
Diet in Pulmonary Tuberculosis. Theo. Senseman, Atlantic City.

The Manifestations of Rheumatism in Children. Margaret P. Brewster, Grantwood.

MEETING OF THE HOUSE OF DELEGATES.

Unfinished business.

ADJOURNMENT

NEW JERSEY ASSOCIATION FOR THE PREVENTION AND RELIEF OF TUBERCULOSIS.

Report of the Executive Committee.

The New Jersey Association for the Prevention and Relief of Tuberculosis began its work May 1, 1906. The summer months were spent in collecting data, in ascertaining what had been done, what needed to be done, and what could be done on the lines of prevention and cure of tuberculosis. Practically not until the fall months was the real problem attacked. The work up to this period had been made possible only through the interest and generosity of a half-dozen people, but immediately its projects were made known to the public, the response for support was spontaneous and liberal throughout the State, thus affording means to carry on the work the first year without a deficit.

The policy of the Association was outlined as follows:—(See p. 155, Dec. 1906, JOURNAL.)

Tuberculosis is no longer a disease that alone concerns physicians and the person afflicted; it concerns every layman, philanthropist, economist—every well person. It is contracted by a germ, and is known to be preventable and curable.

Following the example of the National Association, this Association created a Tuberculosis Ex-

hibit as a medium through which popular attention would be attracted to tuberculosis. The exhibit is made up of 150 photographs, showing tenement house conditions in New Jersey, models of out-door treatment at the various sanatoria throughout the country, and charts showing the proportionate death rate from tuberculosis. There is a model of the Loomis Sanatorium, Ray Brook Sanatorium, Tucker Tent, and a model of tent, showing home treatment, furnished by Mr. Charles J. Fisk, Plainfield. There are full-sized models of a dark interior bedroom, typical of the rooms in which many of the poorer class contract tuberculosis, and an adjoining room with open windows, clean iron bed, and a model of Dr. Knopf's Window Tent. The exhibits are all labeled, and throughout there is an effort to make the lesson plain so that it will be readily understood by all.

The exhibit was first shown in Elizabeth in January, with an attendance of 700; then in Paterson, where the attendance was 1,000; in Plainfield, 3,500; in Orange, 1,000; in Millville, 1,500; in Bridgeton, 1,500, and in Vineland, 1,200; a total attendance of 10,400. Through these exhibits 30,000 circulars on "Health and Consumption" were distributed by the local committee, being placed in the pay envelopes of factory employees, wrapped in laundry and store bundles, placed on the counters in stores, and distributed through the churches. The superintendent of schools in the various communities in which the exhibit was shown was asked to send pupils to the exhibit under the direction of teachers. Thus suggestion was carried to thousands. The educational effect of the exhibit is incalculable, bringing, as it does, graphic object lessons of methods of prevention and cure.

The first active work of the Association was the organization of a local committee in Camden, the meeting being called at the instance of the Mayor, in his office. Committees were rapidly formed in Elizabeth, Paterson, Trenton, Jersey City, Millville, Bridgeton, Newark, Vineland in the order named. Plainfield took the initiative in organizing its own committee, and likewise Orange, the latter previous to the organization of the State Association. The method of organization of these committees has been practically the same in each community—that is, to secure some influential person, usually the Mayor, to invite to his office the Board of Health, leading physicians, superintendent of schools, a few clergymen, some influential business men, and two or three public-spirited women, the effort being to get fifteen to twenty such people together to consider the need and advisability of organizing a tuberculosis committee. The Executive Secretary has always been present at these meetings and outlined what a local committee could do through prevention and cure, and has suggested the lines of organization, which resulted in the election of a permanent Chairman, Secretary, Treasurer, and an Executive Committee. These committees take up the local problem and begin the method of education, following in a general way the outline of the Executive Secretary, but concentrating their efforts to the local need, which may differ in various communities. For instance, in factory districts, such as Jersey City, Millville, Bridgeton, Vineland, and Trenton, the effort is directed toward awakening factory employees to the danger of associating with the careless consumptive, this by noon lectures, the distribution of literature, the posting of "Don't Spit" cards throughout fac-

tores, and advocating the use of spittoons. Local Boards of Health are urged, through the local committees, to register all cases of consumption, not for publication, but for public protection, and to disinfect all houses in which consumption has existed.

Each community is urged by the Executive Secretary to have its own hospital to receive its advanced cases, and, where possible, to provide sanatoria for its incipient cases. The municipality of Newark has set aside \$20,000 for the maintenance and equipment of a hospital for consumptives, using its property at Verona; the municipality of Paterson has set aside \$5,000 for its hospital, and is asking for \$7,000 more; Orange is considering the establishment of a Day Camp for the treatment of tuberculosis; and the Freeholders of Hudson County have appropriated about \$10,000 for sanatoria at Snake Hill, accommodating about 200 patients. Orange and Lakewood have trained nurses for tuberculosis patients. These are some of the results of agitation of the subject during the past year.

The Association has lost no opportunity, during the year, to educate the public as to the means of preventing infection. Every editor of newspapers throughout New Jersey was asked if he would publish articles on tuberculosis, furnished by the State Association. Out of this number eighty-three responded favorably. During the year eight articles on consumption have appeared in these eighty-three papers. There have been thirty-five lectures given on tuberculosis, reaching about 2,500 people. Some of these have been illustrated by stereopticon views, showing conditions under which tuberculosis breeds, and methods of out-door treatment and cure.

The State Medical Association at Atlantic City, the State Sanitary Association at Lakewood, the National Tuberculosis Conference at Washington, and the State Federation of Women's Clubs at Asbury Park, were visited and addressed by the Executive Secretary, and their interest in the movement was secured. The State Federation of Women's Clubs passed a resolution to make the study of tuberculosis one of its objects for the next two years.

Not to confine the work to the northern part of the State, the Executive Secretary visited the glass factory districts in South Jersey, and in Millville and Bridgeton formed local tuberculosis committees. The alarming condition of these districts was found to be indifference and the people unaware of the danger of infection. The inactivity of Boards of Health, the absence of warning cards against spitting, and ignorance of the simplest methods of prevention were found to be factors in the spread of the disease. One man in Millville said pathetically, after an address of the Executive Secretary, that if he had known twenty years ago what he had just been told about prevention, his family would all be alive to-day; that all had died of consumption.

The public schools have been reached by four lectures to Teachers' County Institutes, and the State Board of Education has been asked to assume the cost of publication of a leaflet on tuberculosis, carrying instruction to children, and to distribute these among the 350,000 school children in New Jersey.

SUMMARY OF THE WORK OF THE YEAR.

Number of lectures given	35
Number of people attending lectures.....	2,500
Local Tuberculosis Committees organized..	10

Number of leaflets, "Health and Consumption"	35,000
Number of newspaper articles appearing... ..	664
Number of hospitals under consideration... ..	4
Tuberculosis Exhibit in Elizabeth, Paterson, Orange, Plainfield, Millville, Bridgeton, Vineland—attendance	10,400

What the Association Wants To Do During the Coming Year.

It is desired to get local committees organized in every city in New Jersey. Those immediately in line for organization, as a result of past year's effort, are Englewood, Montclair, New Brunswick, Beverly, Asbury Park, and Atlantic City. Thus far the largest cities only have been reached, but the country districts will not be overlooked; to stimulate the interest of the local committees already organized, and to help them in their local educational work; to urge upon municipalities the necessity of each caring for their own consumptives, by the provision of hospitals and sanatoria; to keep in close touch with the State Sanatorium at Glen Gardner, urging each community, from which come applicants for admission to the sanatorium, to follow in a personal way all cases either admitted or rejected from the sanatorium, giving in the homes such supervision as they cannot receive if rejected at the sanatorium; to place the State Exhibit at Asbury Park and Atlantic City for several weeks during the summer, where it will carry its educational suggestion to people who come from all over New Jersey for their one day or week's outing; to secure, through local committees, a close coöperation between themselves and labor unions, asking that they advocate noon lectures, and the placing of spittoons and "Don't Spit" cards throughout all factories in which they are employed, and to use their press as a means of education; to urge Mayors of cities to follow the example of the President of the United States, in issuing an order to prevent spitting in all public buildings, restricting cleaning to certain hours, and compelling the use of individual toilet articles; to give a greater number of lectures, and to distribute a greater number of leaflets; to urge that the law providing for registration of all consumptive cases shall become mandatory.

Current Medical Literature.

Enlarged Prostate, Operation for.—

Cathelin, *Annales des Maladies des Organes Génito-urinaires*, November 17, 1906, recommends the following: The patient is placed in the sacrovertical position, the operator standing. A grooved catheter is introduced and the bladder emptied and inflated with air. The skin and bladder wall are then cut through above the pubis. The incision is made just large enough to admit the finger, and is kept open by an instrument which serves as a guide for the finger. A transverse perineal incision is then made in front of the rectum. The left index finger is introduced suprapubically, not for the purpose of pushing the gland downward, but to serve as a guide in its enucleation and to prevent wounding the vesical mucosa. The right index finger makes a subfascial enucleation, aided by tenacula forceps and hooked retractor, finally freeing the retropubic lobe till the gland is held only by the urethra; the seminal vesicles and vasa deferentia being plainly visible. The urethra on being exposed by the finger is cut across in two places in the prostatic portion and

the gland removed in one whole piece. A gauze drain is placed in the bladder, and after a few days a catheter is introduced and kept in place until the perineum is closed. The suprapubic opening is closed by a suitable gauze pad.

Treatment of Chronic Urethral Discharge.

—S. L. Gans describes the methods which have commended themselves to his judgment. He was the term *urorrhæa* to signify the sticky discharge which follows a prolonged or severe attack of urethritis. This is the product of over-active mucus glands or relaxed vessels. All local treatment has a tendency to increase the condition, except in some cases which will respond to the local injection of a few minims of 1-2000 adrenalin solution. General tonics and hygiene are called for, and cold spinal sponges in the morning will soon effect a cure, if the patient can be persuaded to abandon the pernicious habit of constantly "stripping" the penis. The author takes up the details of instrumentation in cases of gleet dependent on a patch or erosion independent of a stricture. Concerning strictures, he says, dilate all strictures except those that are resilient, cartilaginous, irritable or bleeding, allowing that the technique is correct. Where a stricture reaches a certain point and persistently refuses to dilate further; where there is repeated and excessive bleeding, or urethral fever, then, regardless of the calibre, a cutting operation is advisable. Internal urethrotomy is indicated when the lesion is at or near the meatus, but external urethrotomy or perineal section should always be done when the stricture is at or near the bulb. A departure from this rule is to invite infection, as the bulb represents the base of a U-shaped tube (urethra) with its consequent bad drainage.—*N. Y. Med. Jour.*, Jan. 26, 1907.

The Pathology of Appendicitis.—Flesch, *Münchener medizinische Wochenschrift*, is inclined to doubt the belief that the appendix is a rudimentary organ or one in the course of retrograde metamorphosis, and suggests that it is possible to attribute to it a useful function. He regards it as a glandular structure placed in the region of the ileocecal valve for the purpose of in some way modifying the conditions existing in this portion of the large intestine where a pronounced change in the character of the intestinal contents and in the direction of their movement takes place. The inflammatory processes that occur in the appendix may be compared to those observed in other glandular organs, and are the result of bacterial infection following local injury or irritation through mechanical or chemical causes. The greater frequency of the disease in certain families indicates that through some inherited peculiarities of structure inflammatory changes are predisposed to, but the inciting cause is a purely individual one. Constipation, which appears to be on the increase among all classes of society, is to be considered as an important factor, and the prophylaxis of the disease demands concerted efforts to combat this tendency by suitable modifications of diet and mode of life.

How Long Shall the Patient Stay in Bed After Abdominal Section?—J. Vance, *N. Y. Medical Journal*, February 6, 1907, declares that there are many advantages to be gained in getting abdominal patients out of bed as soon as possible. The personal comfort of the patient is

greatly increased, the catheter is practically always avoided, and when sitting up they can pass the time agreeably by reading or writing. They eat their meals with a far greater relish than when in bed. Elimination by the bowels, kidneys and skin are far better, and consequently digestion is greatly aided. With the ability of the intestine to digest comes appetite, strength and confidence. In the aged all of these advantages are greatly increased. In fact, while younger patients will do well in bed and better out, old patients will not do well at all in bed, and getting them out of bed early becomes, not a procedure of choice, but of necessity. Recumbency for any length of time embarrasses respiration and heart action at any age, but after sixty or sixty-five years of age this embarrassment is so great as to cause hypostatic pneumonia in the majority of patients. By sitting these patients up early, the general improvement of metabolism gives to the patient that buoyancy of mental condition which is so very necessary to the successful treatment of the aged. There are no disadvantages to the out-of-bed treatment, but there are certain dangers, the first and greatest of which is rupture of suture or ligature, causing secondary hemorrhage or the escape of poisonous material into the peritonum, as, for instance, the slipping of a ligature of an ovarian pedicle or the rupture of a sutured intestine. Those patients best kept in bed are (a) all pelvic cases in which traumatism has been very great and the patient is much weakened by operation; (b) all cases of intestinal surgery in which healing depends to a large extent on absolute quiet of parts; (c) patients greatly emaciated and exhausted by disease prior to operation; (d) cases of profound, acute or chronic anemia, and (e) neurasthenics, no matter how light the operation. In a word, all patients in whom nature requires rest and quiet should be bed patients.—*N. Y. Medical Record*.

The Surgical Cure of Cancer of the Cervix Uteri.—Faure speaks in very high terms of Wertheim's operation, which he believes gives better results than either the abdominal or vaginal hysterectomy as ordinarily performed. During the years 1902 to 1905 he has performed this operation on eighteen patients, twelve of whom survived. One of the twelve had an almost immediate recurrence, one disappeared from under observation, and one died from recurrence at the end of twenty-three months. The remaining nine are reported to be in good health and to present no sign of recurrence, the length of time which has elapsed since operation varying from one year and four months to four years and eight months.—*La Presse Medicale*, Mar. 2, 1907.

Physio-Therapy and Surgery.—Physio-therapy is in principle and practice the ally of conservative surgery or the surgery that aims to preserve structure rather than mutilate or destroy it. The discovery of anæsthesia, the principles of surgical cleanliness, and the Esmarch method of bloodless operations, have made invasion of the body by the knife comparatively safe. This fact accounts for the great strides that have been made in the department of operative surgery and the assiduous cultivation of mechanical skill on the part of the operating surgeons of to-day. Whether the operative surgery of to-day signifies actual scientific progress in medicine is more than questionable. During the times of Billroth, Lan-

genbeck, and Gross the essence of surgical education was the knowledge of *when* and *why* to operate. To-day it seems to be all-important to know *how* to operate. Such is the effect of the example of a mechanical genius like Lawson Tait on the many men of much smaller calibre who attempt to follow in his footsteps. This accounts for the present age of unnecessary operations. Clinically operative surgery thrives at the expense of other lines of practice. That a reaction is bound to follow this era of surgical overwork, especially in gynecology, is plain to any one who is familiar with the history of medicine and knows the causes that led up to the present dominating influence of operative surgery. The development of conservative methods along physiological lines will eventually force surgery into its proper place as the handmaid of medicine. Abstracting from the glamour of a modern surgical operation and the mechanical skill displayed, there is usually not much of the true scientific medical element in it. Lawson Tait and his disciples defer a diagnosis until after the abdominal section. Joints are resected that might be restored, amputations are made that might be avoided, etc., etc., *ad absurdum*. The physiological therapist has a well-equipped armamentarium to choose from before he resorts to the knife. Mechanical skill should not be the end and purpose of a surgical education, but always be the means to the end.—*The International Journal of Therapy*, March, 1907.

The Treatment of Incipient Insanity.—White, in the *British Medical Journal*, March 9, 1907, classifies incipient and borderland cases of insanity as follows: Forms met with in early life. The backward or deficient. Abnormalities in infants are often unnoticed until the child fails to begin to talk or to take notice. Little can be done in these early developmental failures, as they represent states of amentia. In such cases treatment is definite. The higher education must be discarded once and for all. The powers of observation must be utilized as far as possible. Boys can be taught the handicrafts, girls the ordinary domestic duties and music. Physical exercises and outdoor games should be encouraged, with daily regularity, and constipation, often habitual in these cases, guarded against. A sluggish circulation always accompanies a poor intellect. The epileptic:—Epilepsy is both an accompaniment and a cause of mental unsoundness in the young. The youthful epileptic, incipiently insane, must lead a country life with outdoor employment and exercise, and follow some handicraft. The periods of mental unsoundness in the epileptic occur either before or after the fits, or when unsoundness replaces the fits in masked epilepsy. These patients are greatly addicted to masturbation; for this they must be watched and corrected; cold baths in the morning, plenty of exercise during the day, a minimum of animal food, a hard mattress and cool bed, tend to overcome this moral defect. The nervous:—The children of neurotic, ill-balanced parents require careful management. They are highly strung, restless, excitable, thin and delicate, but are very receptive and intelligent. They must have short lessons, reside at the seaside where the climate is bracing, and have an abundance of outdoor air and recreation, but no unnatural excitement. The moral imbecile:—This is a child with a morbid defect in the feelings, affections, inclinations, temper, habits and moral dispositions. Intellectually, there is little

if any abnormality. He is unkind, cruel, and irritable; sulks when corrected, lies, and is addicted to petty thefts; the victim of bad habits, sexual immorality, masturbation and sexual perversion. Such children must be placed under strict discipline. They are generally of robust constitution and need abundance of physical exercise. The incipient melancholic and maniacal:—Mania is very rare before puberty is fully established; melancholia is also rare, but less so than mania. Mental unsoundness is, however, frequently associated with developing manhood and womanhood. All such patients are liable to act impulsively and without warning, and frequently they attempt suicide. Removal from home and change of surroundings are essential. They can be well treated as single cases, even without certification. When mania occurs in the young there is generally some insane inheritance and definite exciting cause. The mania is usually preceded by an incipient stage of depression. Sea voyages should never be recommended in cases of incipient melancholia, as the risk of suicide by drowning is too great. The borderland delusional:—Many hypochondriacal cases come under this head. The mental unsoundness associated with self-abuse is often characterized by hallucinations of ordinary sensation. The premature dementia:—This is a better term than "Dementia præcox," and depicts the mental decadence occurring between puberty and adolescence. The predisposing cause is a neurotic inheritance in town dwellers where hypercivilization obtains, and the exciting causes are over-education, febrile disorders, influence and stress. Forms met with in adult life. Incipient mania and melancholia:—The early symptoms should be recognized and treated by the medical attendant. The patient and those around him must be safeguarded, and all sources of danger removed. But restraint by straitjacket or other means is never justified. Hot baths are of value. It must be borne in mind that the melancholic patient who fears injury at the hands of others, is prone to suicide. Borderland delusional insanity:—Delusions of persecution are common, and many refer to the various bodily organs. Where the delusion refers to a single individual, has no basis of existence, and is often repeated with threats of bodily harm, action must be taken lest a criminal assault ensue. These cases are always chronic. Borderland alcoholic insanity:—This is the outcome of chronic abuse of stimulants, and the treatment is to remove the cause, build up the system, and divert the mind. Forms met with in old age:—Incipient senile mania and melancholia; borderland paralytic insanity; and incipient senile, dementia.—*N. Y. Medical Journal*.

Etiology of Infantile Tuberculosis.—A. Calmette (*La Presse Méd.*, Dec. 26, 1906) claims that tubercular infection in children is rarely from milk, and more rarely occurs by way of the respiratory tract. The infection comes generally by way of the mouth, through the many objects that the child puts in his mouth which have lain on the floor or elsewhere, and have been infected by germs brought into the house by members of the family. The infant creeps about the house on all fours and then carries the hands soiled with dust to his mouth, or puts all sorts of objects in the mouth, carrying germs with them, which are swallowed or carried into the throat. Here they are taken up by the lymphatic structures and carried to the glands, which accounts for the frequent infections of the lymphatic structures in children.

Again, the food that is to be eaten is contaminated by the germs from tuberculous members of the family and germs are introduced with it. Although man is capable of infection by bovine tuberculosis, infection by human tuberculosis is three times as frequent. We must educate the public to the knowledge of this method of infection by way of the gastro-intestinal tract and teach them to prevent the infant from ingesting germs by way of the hands. We should not stop sterilizing milk, but should go further in our prophylaxis. The mesenteric glands of the infant form a marvelous protective mechanism, which filters out many bacteria and destroys them, while others are committed to the circulation and carried to various organs. The primary tubercular lesion is always vascular. In the adult we have a less active glandular protection than in the child, and hence the respiratory infection is much more frequent. Since sterilization of milk has become general, the number of gastro-intestinal diseases in infants has decreased, but the number of cases of tuberculosis has not been lessened. This shows how little the sterilization of milk has accomplished in the removal of the causes of tuberculosis.—*Amer. Jour. of Obstetrics and Diseases of Women and Children*, May, 1907.

Personal.

Dr. John C. Albright, of South Amboy, who has been confined to his residence for seven weeks, by rheumatism with cardiac complications, we are pleased to report is convalescent.

Dr. Edgar B. Grier, of Elizabeth, was knocked down by an automobile recently and severely injured, and **Dr. Edward R. O'Reilly**, of the same city, who underwent an operation for appendicitis, died on May 27. We hear as the *JOURNAL* goes to press that Dr. Grier will recover.

Dr. David Stephens, of New Brunswick, who was for more than forty years a practicing physician and druggist, and for about twenty years the faithful Secretary of the Middlesex County Medical Society, was compelled to relinquish work—being a sufferer from locomotor ataxia, and after two months in the Wells Memorial Hospital in that city, has gone to his native home, Addison, N. Y., for the summer.

We note articles in our exchanges contributed by members of our State Society: by our President, **Dr. Alex. Marcy, Jr.**, on "Prophylaxis and Treatment of Diphtheria with Antitoxin" in the January *Yale Medical Journal*; **Dr. Charles J. Kipp**, on "Chrysophanic Acid Kerato-Conjunctivitis," in the May 18th issue *Journal A. M. A.*; **Dr. C. R. O'Crowley**, on "The Internal and External Remedies in Urinary Diseases and Their Comparative Value," in the May 18th issue of the *Medical Record*; **Dr. G. K. Dickinson**, on "Holes in the Mesentery with Herniation of the Intestine," in the April 13th *Journal A. M. A.* In *The Independent*, Santa Barbara, Cal., is an account of a speech by **Dr. Luther M. Halsey** before the Santa Barbara County Medical Society, of which he was the guest, May 13th, in which he advocated the movement in favor of having a medical man as a member of the President's cabinet at Washington.

The abolition of the Congressional free seed delivery should excite a cackle of protest from every American poultry yard.—*N. Y. Tribune*.

Book Review.

PHYSICAL DIAGNOSIS, WITH CASE EX- AMPLES OF THE INDUCTIVE METHOD.

By Howard S. Anders, A. M., M. D., Professor
of Physical Diagnosis, Medico-Chirurgical
College, Philadelphia, etc.

Illustrated; 456 pages.

D. Appleton & Co., New York and London.

This work of Dr. Anders is precise, comprehensive and thoroughly up to date. It seeks to teach the diagnostician systematic habits of procedure in order to avoid the errors of "a snap" diagnosis. It is attractively and abundantly illustrated—the Röntgenograms (32 plates) being an especial feature. The subjects of inspection, palpation, percussion and auscultation receive unusual attention. Both students and practitioners will be taught a method of diagnosis from these chapters. The section on differential diagnosis of the affections of the principal organs of the abdomen is alone worth the price of the book. We congratulate the author and the medical profession on the production of this publication.

Board of Health of the State of New Jersey. Monthly Statement—April, 1907.

The number of deaths reported to the Bureau of Vital Statistics during the month ending April 15, 1907, was 3,653, an increase of 512 over the number reported during the previous month. This increase was not limited to any particular group of affections, but was distributed among twelve of the eighteen selected causes of death which are named in the following table, and it also extended to many other diseases. It appears to be probable that this increase in mortality has been mainly due to the unfavorable influence upon health which is exerted by the extreme weather changes which have been experienced during the past month. The excess of deaths from all diseases of the respiratory system, compared with those which occurred in the month ending March 15, 1907, was 127; excess of deaths from diseases of the circulatory system, compared with previous month, 61, and excess of deaths from diseases of the nervous system, 51. The prolonged low temperature of a late spring depresses the vitality of persons who are advanced in years, and affects unfavorably many individuals who are in feeble health. By ages, there were 595 deaths among infants under one year; 285 deaths of children over one year and under five years, and 1,160 deaths of persons aged sixty years and over. Typhoid fever caused 33 deaths, showing a decrease of 6 from the previous month. These figures are also slightly below the average number of deaths (34) from this disease for the past nine months. Cerebrospinal meningitis shows a decided increase, the number of deaths from this cause having been 39, while the figures for the previous month were 18, and the average for the past nine months 23. The mortality from scarlet fever (34) is nearly double that of the previous month (18).

The following table shows the number of certificates of death received in the State Bureau of Vital Statistics during the month ending April 15, 1907, and also the number of deaths from certain selected causes, compared with the average for the previous nine months:

CAUSES OF DEATH

	Death Certificates Received, April, 1907	Average for nine previ- ous months
Typhoid fever.....	33	37
Measles.....	21	9
Scarlet fever.....	34	11
Whooping cough.....	18	32
Diphtheria and Croup.....	67	54
Malarial fever.....	0	3
Tuberculosis of lungs.....	403	286
Tuberculosis of other organs.....	49	46
Cancer.....	127	113
Cerebro spinal meningitis.....	39	22
Diseases of nervous system.....	492	374
Diseases of circulatory system.....	407	278
Diseases of respiratory system (Pneumonia and Tuberculosis excepted).....	277	161
Pneumonia.....	449	227
Infantile diarrhoea.....	54	229
Diseases of digestive system (Infantile Diarrhoea excepted).....	202	188
Bright's disease.....	260	174
Snicide.....	27	26
All other causes.....	694	571
Total for April, 1907.....	3653	
Average for previous nine months.....		2841

During the month ending April 15, 1907, deaths occurred in the cities of New Jersey, having 10,000 inhabitants and over, as follows:

CITIES	Population, Estimated for 1907	No. of deaths reported	Deaths under five years	Consumption	Diphtheria
Atlantic City.....	41,495	81	14	10	4
Camden.....	86,334	203	60	16	3
Bridgeton.....	13,508	35	4	9	0
Millville.....	12,404	16	3	2	0
East Orange.....	26,643	41	10	3	2
Montclair.....	17,333	28	6	0	0
Newark.....	298,177	499	231	65	6
Orange.....	26,885	38	10	5	0
Bayonne.....	46,078	47	16	7	2
Harrison.....	13,714	16	7	2	2
Hoboken.....	67,910	129	37	13	2
Jersey City.....	243,205	398	108	54	10
Town of Union.....	17,732	28	6	3	2
West Hoboken.....	31,477	21	6	4	0
Trenton.....	88,529	197	36	27	4
New Brunswick.....	24,384	65	17	6	0
Perth Amboy.....	29,173	29	13	1	2
Long Branch.....	13,507	28	4	5	0
Morristown.....	12,498	28	10	2	0
Passaic.....	41,861	56	22	6	0
Paterson.....	114,072	193	50	22	3
Elizabeth.....	63,861	111	35	9	2
Plainfield.....	19,708	39	4	5	0

Typhoid Fever: 1 death in Atlantic City; 2 each in Camden and Hoboken; 3 in Jersey City; 8 each in Newark and Trenton.

Scarlet Fever: 1 each in East Orange, Trenton, New Brunswick, Perth Amboy, Morristown and Paterson; 2 each in Camden, Elizabeth and Orange; 4 in Hoboken; 5 in Newark; 7 in Jersey City.

Food and Drugs.—During the month ending April 30, 1907, 319 samples were purchased for examination, under the direction of the State Board of Health. Of 133 specimens of milk, 18 per cent. were adulterated; of 40 specimens of butter, 37.5 per cent.; of all foods and drugs, 24.3 per cent. were adulterated.

Bacteriological Examinations for Diagnosis.—During the month ending April 30, 1907, 757 specimens were examined for diagnosis, as follows: From suspected cases of diphtheria, 285; tuberculosis 337; typhoid fever, 116; malaria, 11; miscellaneous, 8.

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Articles are, in many instances, listed in this Index under more than one head. All important business items of the annual meeting, as recorded in the September Supplement, will be found under the heading "Transactions of the House of Delegates." The printer having, by mistake, given in the October Journal the same page numbers as those in the September Supplement, each item in this Index from the Supplement has its page number marked with an asterisk, thus *77, etc. Reports of County Societies and local organizations within their bounds, as well as those of State and National medical organizations, will be found under "Societies." Brief items from current medical literature are indexed under "Current Literature." The abbreviations are as follows: (O) Original Articles; (E) Editorials; (C) Correspondence; (BR) Book Review.

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OFFICIAL LIST

OF THE

FELLOWS, OFFICERS AND MEMBERS

OF

THE MEDICAL SOCIETY OF NEW JERSEY.

1906.

FELLOWS.

All persons who shall have been, or may hereafter be President of the Society, shall rank as Fellows, and be entitled to all the privileges of delegated members.
The dates represent the year of election as President.

Those marked thus (*) are deceased.

*Robert McKean	1766	*Henry Van Derveer	1836
*William Burnett	1767	*Lyndon A. Smith.....	1837
*John Cochran	1768	*Benjamin H. Stratton.....	1838
*Nathaniel Scudder	1770	*Jabez G. Goble.....	1839
*Isaac Smith	1771	*Thomas P. Stewart.....	1840
*James Newell	1772	*Ferd. S. Schenck	1841
*Absalom Bainbridge	1773	*Zachariah Read	1842
*Thomas Wiggins	1774	*Abraham Skillman	1843
*Hezekiah Stites	1775	*George R. Chetwood	1844
* * * * *		*Robert S. Smith	1845
*John Beatty	1782	*Charles Hannah	1846
*Thomas Barber	1783	*Jacob T. B. Skillman.....	1847
*Lawrence Van Derveer	1784	*Samuel H. Pennington.....	1848
*Moses Bloomfield	1785	*Joseph Fithian	1849
*William Burnett	1786	*Elias J. Marsh	1850
*Jonathan Elmer	1787	*John H. Phillips	1851
*James Stratton	1788	*Othniel H. Taylor	1852
*Moses Scott	1789	*Samuel Lilly	1853
*John Griffith	1790	*A. B. Dayton	1854
*Lewis Dunham	1791	*J. B. Coleman	1855
* * * * *		*Richard M. Cooper	1856
*Isaac Harris	1792	*Thomas Ryerson	1857
* * * * *		*Isaac P. Coleman	1858
*Elisha Newell	1795	*John R. Sickler	1859
* * * * *		*William Elmer	1860
*Jonathan F. Morris.....	1807	*John Blane	1861
*Peter I. Stryker	1808	*John Woolverton	1862
*Lewis Morgan	1809	*Theo. R. Varick	1863
*Lewis Condict	1810	*Ezra M. Hunt	1864
*Charles Smith	1811	*Abraham Coles	1865
*Matt. H. Williamson.....	1812	*Benjamin R. Bateman	1866
*Samuel Forman	1814	Jno. C. Johnson	1867
*John Van Cleve	1815	*Thomas J. Corson	1868
*Lewis Dunham	1816	*William Pierson	1869
*Peter I. Stryker	1817	*Thomas F. Cullen	1870
*John Van Cleve.....	1818	*Charles Hasbrouck	1871
*Lewis Condict	1819	*Franklin Gauntt	1872
*James Lee	1820	*T. J. Thomason	1873
*William G. Reynolds.....	1821	*G. H. Larison	1874
*Augustus R. Taylor.....	1822	*William O'Gorman	1875
*William B. Ewing.....	1823	*Ino. V. Schenck	1876
*Peter I. Stryker	1824	*Henry R. Baldwin.....	1877
*Gilbert S. Woodhull.....	1825	*John S. Cook	1878
*William D. McKissack.....	1826	*Alex. W. Rogers	1879
*Isaac Pierson	1827	*Alex. N. Dougherty	1880
*Jephtha B. Munn	1828	*Lewis W. Oakley.....	1881
*John W. Craig.....	1829	*John W. Snowden	1882
*Augustus R. Taylor.....	1830	*Stephen Wickes	1883
*Thomas Yarrow	1831	*P. C. Barker	1884
*Fitz Randolph Smith.....	1832	*Joseph Parrish	1885
*William Forman	1833	Charles J. Kipp	1886
*Samuel Hayes	1834	John W. Ward.....	1887
*Abm. P. Hageman.....	1835	H. Genet Taylor	1888

FELLOWS—Continued.

*B. A. Watson	1889	C. R. P. Fisher.....	1898
*James S. Green.....	1890	Luther M. Halsey	1899
Elias J. Marsh	1891	*William Pierson.....	1900
George T. Welch	1892	John D. McGill	1901
John G. Ryerson	1893	E. L. B. Godfrey	1902
O. H. Sproul	1894	Henry Mitchell	1903
William Elmer	1895	Walter B. Johnson	1904
T. J. Smith	1896	Henry W. Elmer	1905
David C. English.....	1897		

HONORARY MEMBERS.

*David Hosack, New York.....	1827	*Ferris Jacobs, Delhi, N. Y.....	1872
*John W. Francis, New York	1827	*C. A. Lindsley, New Haven, Conn.....	1872
*John Condict, Orange.....	1830	*Wm. Pepper, Philadelphia.....	1874
*Usher Parsons, Rhode Island.....	1839	S. Weir Mitchell, Philadelphia.....	1876
*Reuben D. Murphy, Cincinnati.....	1839	Cyrus F. Brackett, Princeton, N. J.....	1880
*Alban G. Smith, New York.....	1839	*Joseph C. Hutchinson, Brooklyn, N. Y.....	1880
*Willard Parker, New York.....	1842	Thomas Addis Emmett, New York.....	1884
*Valentine Mott, New York.....	1843	*Isaac E. Taylor, New York.....	1884
*Jonathan Knight, New Haven.....	1848	*D. Hayes Agnew, Philadelphia.....	1886
*Nathaniel Chapman, Philadelphia.....	1848	*Joseph Leidy, Philadelphia	1886
*Alexander H. Stephens, New York.....	1848	Frederick S. Dennis, New York.....	1893
*John C. Warren, Boston	1849	*John H. Ripley, New York.....	1893
*Lewis C. Beck, New York.....	1850	Virgil P. Gibney, New York.....	1893
*John C. Torrey, New York.....	1850	*William Pierson, Orange, N. J.....	1894
*George B. Wood, Philadelphia.....	1853	Abram Jacobi, New York.....	1896
*H. A. Buttolph, Short Hills, N. J.....	1854	*Virgil M. D. Marcy, Cape May City.....	1896
*Ashbel Woodward, Franklin, Conn.....	1861	*Samuel H. Pennington, Newark, N. J.....	1897
*Thomas W. Blatchford, Troy, N. Y.....	1886	Alfred A. Woodhull, Princeton, N. J.....	1901
*Jeremiah S. English, Manalapan, N. J.....	1867	J. Leonard Corning, New York.....	1902
*Stephen Wickes, Orange, N. J.....	1868	John Allen Wyeth, New York.....	1903
*S. O. Vanderpool, Albany, N. Y.....	1872	William K. Van Reypen, U. S. N.....	1903
*Joseph Parrish, Burlington, N. J.....	1872	Lawrence F. Flick, Philadelphia, Pa.....	1903

OFFICERS.

ALEXANDER MARCY, JR., <i>President</i> Riverton			
EDWARD J. ILL, <i>1st Vice Pres</i>	Newark	DANIEL STROCK, <i>Cor. Secretary</i>	Camden
DAVID ST. JOHN, <i>2nd Vice Pres</i>	Hackensack	WM. J. CHANDLER, <i>Rec. Secretary</i> ..	South Orange
B. A. WADDINGTON, <i>3rd Vice Pres</i>	Salem	ARCHIBALD MERCER, <i>Treasurer</i>	Newark

PERMANENT DELEGATES.

ATLANTIC COUNTY.		CAMDEN COUNTY.	
W. Blair Stewart, Atlantic City.....	1900	Duncan W. Blake, Gloucester.....	1895
E. A. Reiley, Atlantic City....	1903	Daniel Strock, Camden.....	1899
W. Edgar Darnall, Atlantic City.	1903	William H. Iszard, Camden.....	1899
J. Addison Joy, Atlantic City.....	1903	William A. Davis, Camden.....	1900
E. C. Chew, Atlantic City.....	1905	Alexander McAlister, Camden.....	1903
Emery Marvel, Atlantic City.....	1906	William S. Jones, Camden.....	1903
		Harry H. Sherck, Camden.....	1903
BERGEN COUNTY.		CUMBERLAND COUNTY.	
Henry C. Neer, Park Ridge.....	1892	S. T. Day, Port Norris.....	1899
David St. John, Hackensack.....	1900	Joseph Tomlinson, Bridgeton.....	1902
Samuel E. Armstrong, Rutherford.....	1901		
BURLINGTON COUNTY.		ESSEX COUNTY.	
Enoch Hollingshead, Pemberton.....	1903	Charles Young, Newark.....	1892
R. H. Parsons, Mt. Holly.....	1903	Joseph C. Young, Newark.....	1892
Walter E. Hall, Burlington.....	1905	Herman C. Bleytle, Newark.....	1896
		William J. Chandler, South Orange.....	1896

PERMANENT DELEGATES.—Continued.

Edward J. Ill, Newark.....	1896
George R. Kent, Newark.....	1896
Daniel M. Skinner, Belleville.....	1896
Charles H. Bailey, Bloomfield.....	1898
Thomas S. P. Fitch, Orange.....	1898
Richard C. Newton, Montclair.....	1898
Joshua W. Read, Newark.....	1898
George A. Van Wagenen, Newark.....	1898
James T. Wrightson, Newark.....	1898
Theron Y. Sutphen, Newark.....	1900
Charles F. Underwood, Newark.....	1900
L. Eugene Hollister, Newark.....	1900
Charles D. Bennett, Newark.....	1900
William B. Graves, East Orange.....	1900
Robert G. Stanwood, Newark.....	1900
Thomas W. Harvey, Orange.....	1901
Aaron K. Baldwin, Newark.....	1902
David E. English, Milburn.....	1903
George B. Philhower, Nutley.....	1903
Richard P. Francis, Montclair.....	1903
Henry L. Coit, Newark.....	1903
Theodore W. Corwin, Newark.....	1903
Richard G. P. Dieffenbach, Newark.....	1903
Edward Staehlin, Newark.....	1903
Livingston S. Hinckley, Newark.....	1903

GLOUCESTER COUNTY.

George E. Reading, Woodbury.....	1893
James Hunter, Jr., Westville.....	1898
Eugene T. Oliphant, Bridgeport.....	1903

HUDSON COUNTY.

James A. Exton, Arlington.....	1898
Jos. M. Rector, Jersey City.....	1900
Fred M. Corwin, Bayonne.....	1900
Geo. E. McLaughlin, Jersey City.....	1900
Mortimer Lampson, Jersey City.....	1900
T. R. Chambers, Jersey City.....	1900
Gordon K. Dickinson, Jersey City.....	1906
Frank D. Gray, Jersey City.....	1906

HUNTERDON COUNTY.

Isaac S. Cramer, Flemington.....	1892
W. S. Creveling, Valley.....	1896
George N. Best, Rosemont.....	1902

MERCER COUNTY.

R. R. Rogers, Sr., Trenton.....	1895
David Warman, Trenton.....	1897
Elmer Barwis, Trenton.....	1898
Thos. H. Mackenzie, Trenton.....	1900
C. F. Adams, Trenton.....	1900
J. C. Felty, Trenton.....	1900
Henry B. Costill, Trenton.....	1902
George H. Franklin, Hightstown.....	1903

MIDDLESEX COUNTY.

Ambrose Treganowan, South Amboy.....	1898
Frank M. Donohue, New Brunswick.....	1900
David Stephens, New Brunswick.....	1903

MONMOUTH COUNTY.

Henry Mitchell, Asbury Park.....	1892
D. McLean Forman, Freehold.....	1901
Edwin Field, Red Bank.....	1901
F. C. Price, Imbstown.....	1901
Samuel Johnson, Asbury Park.....	1901
Cyrus Knecht, Matawan.....	1902

MORRIS COUNTY.

Levi Farrow, Middle Valley.....	1895
Cuthbert Wigg, Boonton.....	1899
Stephen Pierson, Morristown.....	1901
F. W. Flagge, Rockaway.....	1901
Calvin Anderson, Madison.....	1901
Britton D. Evans, Morris Plains.....	1902
A. A. Lewis, Morristown.....	1903

OCEAN COUNTY.

C. L. Lindley, Lakewood.....	1905
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PASSAIC COUNTY.

Walter B. Johnson, Paterson... ..	1892
P. A. Harris, Paterson.....	1893
George H. Balleray, Paterson.....	1896
John L. Leal, Paterson.....	1899
C. H. Scribner, Paterson.....	1900
Robert M. Curtis, Paterson.....	1900
John T. Gillson, Paterson.....	1900
Andrew F. McBride, Paterson.....	1902

SALEM COUNTY.

B. A. Waddington, Salem.....	1893
W. H. James, Pennsville.....	1900
Henry Chavanne, Salem.....	1900

SOMERSET COUNTY.

S. O. B. Taylor, Millstone.....	1897
J. P. Hecht, Somerville.....	1898
A. L. Stillwell, Somerville.....	1900
Mary E. Gaston, Somerville.....	1902

SUSSEX COUNTY.

B. W. Ferguson, Beemerville.....	1899
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UNION COUNTY.

Alonzo Pettit, Elizabeth.....	1893
E. B. Silvers, Rahway.....	1893
J. Ackerman Coles, Scotch Plains.....	1896
T. H. Tomlinson, Plainfield.....	1896
James S. Green, Elizabeth.....	1900
N. L. Wilson, Elizabeth.....	1900
T. N. McLean, Elizabeth.....	1903

WARREN COUNTY.

G. W. Cummins, Belvidere.....	1903
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MEMBERS OF COUNTY MEDICAL SOCIETIES

COMPOSING THE MEDICAL SOCIETY OF NEW JERSEY JUNE 1906.

ATLANTIC COUNTY.

Society organized June 7, 1880. Annual meeting first Friday in January.

E. C. Chew, *Pres.*, 28 So. Ky. ave., Atl. City.
E. H. Harvey, *Vice-Pres.*, 20 N. Fla. ave., Atl. C.
Edward Guion, *Sec.-Treas.*, 1408 Atl. ave., Atl. C.
A. B. Shimer, *Rep.*, 606 Pacific ave., Atl. City.
J. O. Adams, Washington, D. C.
Clara K. Bartlett, 11 No. N. Car. ave., Atl. City.
David A. Berner, LeGrand Apartments, Atl. City.
Theophilus H. Boysen, Egg Harbor.
F. C. Burt, Hammonton.
Walt P. Conaway, 1723 Pac. Ave., Atl. City.
Albert D. Cuskaden, 2 So. Mich. Ave., Atl. City.
W. Edgar Darnall, 1704 Pacific Ave., Atl. City.
W. Price Davis, 1721 Pacific Ave., Atl. City.
Jos. F. DeSilver, Galbraith Apt's., Atl. City.
H. Stokes Doriss, 119 So. S. Car. Ave., Atl. City.
Thomas G. Dunlap, 921 Pacific Ave., Atl. City.
Arthur E. Ewens, 1512 Pacific Ave., Atl. City.
Walter B. Fayerman, 29 No. Ohio Ave., Atl. City.
C. M. Fish, Pleasantville.
M. G. Frank, Egg Harbor.
C. Garrabrant, 1001 Atl. Ave., Atl. City.
G. P. Gehring, Bakersville.
Walter A. Hickman, 612 Pacific Ave., Atl. City.
Emory E. Howard, Somers Point.
Milton S. Ireland, 23 So. Cal. Ave., Atl. City.
H. C. James, Mays Landing.
W. E. Jonah, 1616 Pacific Ave., Atl. City.
J. Addison Joy, 1920 Pacific Ave., Atl. City.
Isaac E. Leonard, 28 No. Iowa Ave., Atl. City.
B. R. Lee, 901 Pacific Ave., Atl. City.
E. H. Madden, Absecon.
T. H. Madden, Collingswood.
Joseph C. Marshall, 1517 Pacific Ave., Atl. City.
Philip Marvel, 1616 Pacific Ave., Atl. City.
Emery Marvel, 811 Pacific Ave., Atl. City.
Victor W. Metzler, LeGrand Apt's., Atl. City.
J. C. McVay, 707 Pacific Ave., Atl. City.
James North, 29 So. Tennessee Ave., Atl. City.
William M. Pollard, 25 So. Car. Ave., Atl. City.
E. E. Parker, Pacific, cor. Penn. Ave., Atl. City.
E. J. Porteous, 811 Pacific Ave., Atl. City.
Eugene L. Reed, 920 Pacific Ave., Atl. City.
Talbot Reed, 104 So. Rhode Island Av., Atl. City.
Thomas K. Reed, 22 No. Penn. Ave., Atl. City.
Edward A. Reiley, 20 So. Tenn. Ave., Atl. City.
Walter Reynolds, 27 So. Indiana Ave., Atl. City.
Wm. F. Ridgeway, Atlantic Ave., Atlantic City.
C. E. Saulsberry, Mays Landing.
George Scott, 1109 Pacific Ave., Atl. City.
Theo. Senseman, 101 St. Charles Pl., Atl. City.
Edward S. Sharpe, 30 No. Georgia Ave., Atl. City.
M. LeRoy Somers, 2012 Pacific Ave., Atl. City.
R. M. Sooy, Pleasantville.
Lewis R. Souder, 1910 Pacific Ave., Atl. City.
W. Blair Stewart, 43 So. N. Car. Ave., Atl. City.
Mary E. Townsend, 13 So. Penn. Ave., Atl. City.
Wm. H. Walling, 1209 Pacific Ave., Atlantic City.
J. Bart. Webster, 132 S. Maryland Ave., Atl. City.
Nevin B. Werst, Egg Harbor City.
R. Woolbert, 26 N. Del. Ave., Atl. City.

Number Members, 60.

BERGEN COUNTY.

Society reorganized February 28, 1854. Annual meeting second Tuesday in April.

Joseph S. Van Dyke, *Pres.*, Hackensack.
Alfred W. Ward, *Vice-Pres.*, Closter.
Daniel A. Currie, *Sec'y.*, Englewood.
David St. John, *Treas.*, Hackensack.
J. W. Proctor, *Rep.*, Englewood.
J. F. Bell, Englewood.
Fred. O. Blenckstone, Oradell.
Samuel E. Armstrong, Rutherford.
M. S. Ayres, Fairview.
H. M. Banks, Englewood.
F. C. Bradner, Englewood.
Guy Otis Brewster, Grantwood.
Margaret P. Brewster, Grantwood.
Chas. D. Brooks, East Rutherford.
Chas. Calhoun, Rutherford.
E. E. Conover, Hasbrouck Heights.
Edgar K. Conrad, Hackensack.
Cornelius A. De Mund, Ridgewood.
John J. De Mund, Ridgewood.
H. C. Elsing, Ridgely Park.
Frank Freeland, Maywood.
Geo. Bancroft Gale, Rutherford.
T. N. Gregory, Englewood.
Frederick S. Hallett, Hackensack.
John J. Haring, Tenafly.
C. W. Harveys, Ridgewood.
Edwin Holmes, Englewood.
Joseph Huger, Fort Lee.
L. P. Knapp, Hackensack.
J. B. W. Lansing, Tenafly.
Howard McFadden, Hackensack.
J. A. Moenig, Park Ridge.
H. C. Neer, Park Ridge.
L. B. Parsell, Closter.
Joseph Payne, Midland Park.
Godfrey Pittis, Allendale.
J. E. Pratt, Dumont.
John Riordan, Carlstadt.
Valentine Ruch, Jr., Englewood.
Ernest Sickenberger, Rutherford.
Michael J. Sullivan, Englewood.
A. A. Swayze, Hackensack.
Theo. E. Townsend, Westwood.
Byron G. Van Horne, Englewood.
Carrie H. Van Horne, Englewood.
B. A. Ver Nooy, Waldwick.
Wm. L. Vroom, Ridgewood.
F. H. White, Hackensack.
J. Talmage Wyckoff, Leonia.
Max Wyler, Fort Lee.
Samuel J. Zabriskie, Westwood.

Number Members, 51.

BURLINGTON COUNTY.

Society organized May 19, 1829. Meets second Wednesday in January, April June and October.
Annual meeting second Wednesday in January.

Joseph Stokes, *Pres.*, Moorestown.
J. E. Blair, *Vice-Pres.*, Burlington.
George T. Tracy, *Sec'y.*, Beverly.
Enoch Hollingshead, *Treas.*, Pemberton.
William P. Melcher, *Rep.*, Mt. Holly.
Alex. Marcy, Jr., *Censor*, Riverton.
John B. Cassaday, *Censor*, Burlington.
W. C. Parry, *Censor*, Hainesport.
Elmer D. Prickett, *Censor*, Mt. Holly.
Irene D. Young, *Historian*, Bordentown.
E. S. Adams, Beverly.
David Baird, Jr., Florence.
R. C. Barrington, Mt. Holly.
C. K. Brick, Marlton.
J. E. Dubell, Columbus.
John J. Flynn, Mt. Holly.
W. H. Giberson, Beverly.
James S. Gilbert, Bordentown.
A. L. Gordon, Burlington.
J. Clifford Haines, Vincentown.
J. Ridgway Haines, Mt. Holly.
Willets P. Haines, Medford.

W. E. Hall, Burlington.
I. W. Hollingshead, 123 S. 18th St., Phila.
J. D. Janney, Cinnaminson.
C. D. Mendenhall, Bordentown.
Emma P. W. Metzger, Riverside.
M. W. Newcombe, Burlington.
R. H. Parsons, Mt. Holly.
W. H. Shipps, Bordentown.
A. H. Small, Riverside.
Frances S. J. Stoddart, Rydal, Pa.
Frank G. Stroud, Moorestown.
G. H. Wilkinson, Moorestown.
J. Boone Winterstein, Moorestown.

CONTRIBUTING MEMBER.

William Martin, Bristol, Pa.

HONORARY MEMBERS.

Charles P. Noble, 1509 Locust St., Phila.
E. P. Townsend, Billings, Mont.
Charles H. Thomas, Philadelphia, Pa.
T. T. Price, Tuckerton, N. J.
Number members, 35.

CAMDEN COUNTY.

Organized August 14, 1846. Annual meeting fourth Tuesday in April.

Joel W. Fithian, *Pres.*, 608 Broadway, Camden.
Sylvan G. Bushey, *Vice-Pres.*, 508 Hadden ave., Camden.
Paul M. Mcclay, *Sec'y.*, 405 Cooper, Camden.
A. Haines Lippincott, *Treas.*, 21, B'way, Camden.
Alfred Cramer, *Hist.*, 433 Penn., Camden.
Ezra B. Sharp, *Rep.*, 412 Broadway, Camden.
Duncan W. Blake, *Censor*, Gloucester.
William A. Davis, *Censor*, 511 Cooper, Camden.
Henry H. Sherk, *Censor*, 2647 West'd. av., C.
John R. Stevenson, *Censor*, Haddonfield.
Joseph S. Baer, 565 Stevens, Camden.
Wilson G. Bailey, Broadway & Pine, Camden.
Dowling Benjamin, 215 Cooper, Camden.
John K. Bennett, Gloucester.
David Bentley, 829 Elm St., Camden.
Walter S. Bray, 902 N. 2nd, Camden.
Robert Casperson, 215 N. 3d, Camden.
Henry H. Davis, 569 Benson, Camden.
Fred. V. Dunn, 623 S. 3d St., Camden.
Alfred M. Elwell, 407 Cooper, Camden.
E. L. B. Godfrey, 400 Linden, Camden.
Clarence R. Grier, 821 S. 5th St., Camden.
Roland I. Haines, 3d & Kaighn ave., Camden.
William J. Halbeisen, 919 S. 5th St., Camden.
John J. Haley, Gloucester.
Levi B. Hirst, 586 Federal, Camden.
Conrad G. Hoell, 565 Benson, Camden.
Frank L. Horning, 623 Market, Camden.
J. Edgar Howard, Haddonfield.
Joseph E. Hurff, Blackwood.
S. D. Ingham, Merchantville.
William H. Iszard, 411 N. 4th, Camden.
Harry Jarrett, Broadway & Cherry, Camden.
William B. Jennings, Haddonfield.
William S. Jones, 3d & Penn., Camden.
William W. Kain, 5th & Pine, Camden.
Wm. Irwin Kelchner, 945 Cooper St., Camden.
Wm. Kensinger, 733 N. 27th St., Camden.
Grant E. Kirk, 1801 Broadway, Camden.
John F. Leavitt, 522 N. 3d, Camden.
Adrienne LeFevre, Blackwood.

Paul N. Litchfield, Mt. Ephraim & Kaighn av., C.
Leslie C. Lyon, Magnolia.
Jessie L. Mahaffey, 7th & Elm, Camden.
Alexander Marcy, Sr., Riverton.
Frederick W. Marcy, 6th & Penn., Camden.
John W. Marcy, Merchantville.
Paul H. Markley, 515 Cooper, Camden.
J. Watson Martindale, 2303 Federal, Camden.
Alexander McAlister, 582 Federal, Camden.
William E. Miller, 8th and Mt. Vernon, Camden.
Marcus K. Mines, 532 West, Camden.
Joseph L. Nicholson, 400 Penn., Camden.
Milton M. Osmun, 815 Broadway, Camden.
Howard F. Palm, 614 N. 2d, Camden.
Edward C. Pechin, 311 N. 3d St., Camden.
William R. Powell, 702 Market, Camden.
William H. Pratt, 406 N. 6th, Camden.
Sophia Presley, 323 N. 4th, Camden.
Ernest S. Ramsdell, 423 Linden, Camden.
Emma M. Richardson, 581 Stevens, Camden.
Ed. B. Rogers, Collingswood.
Horace L. Rose, 9th & Federal Sts., Camden.
Orris W. Saunders, 1813 S. 6th, Camden.
E. A. Y. Schellenger, 429 Cooper, Camden.
Jennie S. Sharp, 412 Broadway, Camden.
J. Anson Smith, Blackwood.
Walter H. Smith, Haddonfield.
William A. Sprenger, 451 Kaighn ave., Camden.
Frank O. Stem, Berlin.
Daniel Stout, Berlin.
Daniel Strock, 818 Federal, Camden.
H. Genet Taylor, 305 Cooper, Camden.
John E. L. Van Sciver, 5th & Berkley, Camden.
William A. Westcott, Berlin.
Charles Wetton, 322 N. 9th St., Camden.
Joseph H. Wills, 3d & Penn., Camden.
Wendell P. Wingender, 8th & Market, Camden.
Orran A. Wood, Magnolia.
E. B. Woolston, Marlton.

HONORARY MEMBERS.

G. W. Boughman, Marshalltown, New Castle Co., Delaware.

CAMDEN COUNTY.—Continued.

HONORARY MEMBERS—Continued.

John B. Davis, 6th & Lawrence, Camden.
Richard C. Dean, U. S. Navy.
Chas. G. Garrison, Merchantville.

J. W. Hewlings Moorestown.
J. Orlando White, 329 Cooper, Camden.
Number Members, 80.

CAPE MAY COUNTY.

Society organized March 12, 1885. Meets first Tuesday in April and October.

Nathan A. Cohen, *Pres.*, Wildwood.
Geo. W. Geyer, *Vice-Pres.*, Cape May C. H.
Marshall F. Lummis, *Sec'y.*, Holly Beach.
Randolph Marshall, *Treas.*, Tuckahoe.
J. Morgan Dix, *Rep.*, Cape May C. H.
Anna M. Hand, *Censor*, Cape May City.
V. M. D. Marcy, Cape May.
B. T. Abbott, Ocean City.
E. J. Asnis, Woodbine.
J. S. Douglass, Tuckahoe.
Jos. E. Garrison, Ocean City.
Joseph Jaffe, Woodbine.
Wm. A. Lake, Cold Spring.

A. L. Leach, Cape May City.
Jos. C. Marshall, Tuckahoe.
James Mecray, Cape May City.
Emlen Physick, Cape May City.
J. M. Slaughter, Wildwood.
Eugene Way, Dennisville.
Julius Way, Cape May Court House.

HONORARY MEMBERS.

Chas. M. Gandy, U. S. Army.
J. H. Ingram, China.
Johnathan Leaming, Cape May Court House.
Number Members, 20.

CUMBERLAND COUNTY.

Society organized December 8, 1818. Annual meeting second Tuesday in April.

John H. Moore, *Pres.*, Bridgeton.
L. H. Bossert, *Vice-Pres.*, Newport.
L. L. Hand, *Sec'y.*, Millville.
Jos. Tomlinson, *Treas.*, Bridgeton.
S. M. Wilson, *Rep.*, Bridgeton.
Frank M. Bateman, Cedarville.
E. B. Bradford, Port Norris.
N. H. Burt, Ocean City.
Ralph Charlesworth, Millville.
Alfred Cornwell, Bridgeton.
E. S. Corson, Bridgeton.
Grafton E. Day, Camden.
S. T. Day, Port Norris.
E. L. Diamant, Bridgeton.
Mary J. Dunlap, Vineland.
H. W. Elmer, Bridgeton.
M. K. Elmer, Bridgeton.
S. Eldridge Ewing, Leesburg.
Edward S. Fogg, Bridgeton.
C. S. Franckle, Millville.
E. Stanley Goudy, Harrison.
W. P. Glendon, Cedarville.
N. S. Greenwood, Rosenhayn.
Jos. T. D. Howard, Washington, D. C.
Ferdinand Jones, Millville.
Reba Lloyd Kumpf, Bridgeton.
John C. Loper, Bridgeton.
A. J. Mander, Millville.
Chas. H. Mayhew, Millville.

Samuel D. Mayhew, Bridgeton.
H. G. Miller, Millville.
C. B. Neal, Millville.
David H. Oliver, Bridgeton.
S. E. Robinson, Waldwick.
Frank R. Sheppard, Millville.
T. J. Smith, Bridgeton.
S. M. Snyder, Greenwich.
Ellsmore Stites, Bridgeton.
J. R. C. Thompson, Bridgeton.
J. W. Wade, Millville.
C. W. Wilson, Vineland.
John H. Winslow, Vineland.

ASSOCIATE MEMBERS.

W. E. Ashton, 2011 Walnut St., Phila., Pa.
J. M. Barton, 1314 Spruce St., Phila., Pa.
J. Chalmers DaCosta, 2045 Walnut St., Phila., Pa.
Judson Daland, 317 S. 18th St., Phila., Pa.
H. A. Hare, 1801 Spruce St., Phila., Pa.
B. C. Hirst, 1821 Spruce St., Phila., Pa.
W. W. Keen, 1729 Chestnut St., Phila., Pa.
Charles P. Noble, 1509 Locust St., Phila., Pa.
Chas. A. Oliver, 1507 Locust St., Phila., Pa.
David Reisman, 162 Spruce St., Phila., Pa.

HONORARY MEMBER.

J. C. Applegate, 3540 N. Broad St., Philadelphia.
Number Members, 42.

ESSEX COUNTY.

Society organized June 18, 1816. Annual meeting first Tuesday in April.

Archibald Mercer, *Pres.*, 31 Wash'n St., New'k.
Herman C. Bleyle, *Vice-Pres.*, 15 Walnut, New'k.
Ralph H. Hunt, *Sec'y.*, 29 Harrison St., E. Orange.
Chas. D. Bennett, *Treas.*, 167 Clinton av., New'k.
Frank W. Pinneo, *Rep.*, 199 Garside St., Newark.
John K. Adams, 475 Main St., Orange.
Walter S. Alexander, 67 Oakwood ave., Orange.
Jeremiah A. Allis, Park St., Upper Montclair.
William H. Areson, Upper Montclair.
Maurice Asher, 20 Court, Newark.
Charles H. Bailey, Bloomfield.
William O. Bailey, 232 S. Orange ave., Newark.

Charles F. Baker, 47 Walnut, Newark.
Aaron K. Baldwin, 291 Plane, Newark.
Samuel H. Baldwin, 473 Clinton avenue, Newark.
Winfred E. Baldwin, 462 Orange, Newark.
Frederick W. Becker, 478 Clinton ave., Newark.
George C. Becket, East Orange.
Alfred C. Benedict, 69 Ward Pl., So. Orange.
Angelo R. Bianchi, 103 Seventh ave., Newark.
Arthur W. Bingham, East Orange.
William D. Bleick, 577 Clinton ave., Newark.
Theo. E. Bleick, 340 Waverly ave., Newark.
David M. Bloom, 235 S. 6th St., Newark.

ESSEX COUNTY.—Continued.

Thomas P. Boyle, 110 Belleville ave., Newark.
 John H. Bradshaw, Orange.
 Stella S. Bradford, Montclair.
 Rudolph Braun, 180 Polk, Newark.
 Isabel M. Bridges, 497 Mt. Pleasant ave., Newark.
 William B. Brien, 585 Valley Rd., W. Orange.
 James S. Brown, Montclair.
 Charles H. Bruckner, 118 Newton, Newark.
 William Buerman, 352 Belmont ave., Newark.
 Charles V. Burke, 537 E. Ferry St., Newark.
 Edwin L. Burns, 269 Broad, Newark.
 Robert L. Burrage, East Orange.
 Carl Buttner, Orange.
 Wellington Campbell, Short Hills.
 Fletcher F. Carman, Montclair.
 Levi W. Case, Montclair.
 Douglas A. Cater, 107 Park, E. Orange.
 Henry M. Chandler, 449 Main, Orange.
 William J. Chandler, South Orange.
 Albion C. Christian, Irvington.
 J. Henry Clark, 12 Walnut, Newark.
 Richard Coe, 11 Warren St., Newark.
 Henry L. Coit, 277 Mt. Prospect ave., Newark.
 John F. Condon, Belleville.
 Hugh F. Cook, 15 Roseville ave., Newark.
 Mary Cook, 91 Mt. Prospect ave., Newark.
 Horace C. Cory, 224 Broad, Newark.
 Everett P. Courtwright, 17 Centre, Newark.
 Theodore W. Corwin, 5 West Park, Newark.
 David H. Crawford, 14 Bridge, Newark.
 Anna M. Cross, 20 Marshall St., Newark.
 Joseph Atwood Cunningham, 591 Warren St., N.
 Peter P. Davenport, Vailsburgh.
 Louis L. Davidson, 173 Spruce, Newark.
 William H. K. Davis, East Orange.
 John Dennis, 287 Belleville ave., Newark.
 Winfield S. DeVausney, 102 Central ave, Newark.
 Frank Devlin, 90 Congress, Newark.
 Hugh Joseph Devlin, 167 Orchard St., Newark.
 Joseph L. Dias, 91 South 9th St., Newark.
 Richard G. P. Dieffenbach, 222 S. Orange av., N'k.
 Daniel M. Dill, 425 So. Orange ave., Newark.
 Wm. S. Disbrow, 151 Orchard St., Newark.
 Samuel W. Dodd, 60 Carleton St., East Orange.
 Walter Dodge, Orange.
 Arthur C. Dougherty, 158 Washington, Newark.
 Edward A. Drummond, 431 7th ave., Newark.
 John L. Duryee, 436 High, Newark.
 Wells P. Eagleton, 15 Lombardy, Newark.
 Sarah M. Edwards, 207 Summer ave., Newark.
 Linn Emerson, 234 Main St., Orange.
 Henry B. Epstein, 455 High, Newark.
 David E. English, Milburn.
 James R. English, 800 Clinton ave., Newark.
 Joseph Fewsmith, 47 Central ave., Newark.
 Joseph L. Fewsmith, 76 Central ave., Newark.
 Arnim Fischer, 539 High, Newark.
 Thomas S. P. Fitch, 14 Prospect St., E. Orange.
 W. Story Foster, 111 Bloomfield ave., Newark.
 Richard P. Francis, Montclair.
 Gustav H. Frederick, 349 Camden, Newark.
 Richard D. Freeman, South Orange.
 Ruel S. Gage, 17 Gould ave., Newark.
 Charles Z. Garside, 130 Garside St., Newark.
 William Gauch, 199 High, Newark.
 Isaac E. Gluckman, 70 Wickliffe, Newark.
 William M. Goodwin, 70 Congress, Newark.
 William B. Graves, 426 Main, E. Orange.
 Thomas N. Gray, East Orange.
 Solomon Greenbaum, 142 W. Kinney, Newark.
 B. A. Greenfield, 205 S. Orange ave., Newark.
 Chauncey B. Griffiths, 145 Monmouth, Newark.
 Emil A. Guenther, 159 W. Kinney, Newark.
 R. A. Giuliana, 269 High St., Newark.
 John F. Hagar, 88 Ferry, Newark.
 Charles W. Hagen, 224 S. Orange ave., Newark.
 John F. Hagerty, 30 Wallace Place, Newark.
 Frederick W. Hagney, 67 Penn. ave., Newark.
 Eleanor Haines, 934 Broad, Newark.
 L. W. Halsey, 49 Church, Montclair.
 Edward H. Hamill, 230 Roseville ave., Newark.
 James T. Hanan, Montclair.
 G. Eugene Harbert, East Orange.
 Hugh M. Hart, 16 Gouveneur, Newark.
 Thomas W. Harvey, Orange.
 Francis R. Haussling, 661 High, Newark.
 E. Zeh Hawkes, 15 Central ave., Newark.
 Joseph H. Haydon, 22 Brientnall Pl., Newark.
 John Hemsath, 36 Spruce, Newark.
 Herman C. H. Herold, 77 Congress, Newark.
 William H. Hicks, 425 So. Orange ave., Newark.
 Livingston S. Hinkleley, 182 Clinton ave., Newark.
 Edgar Holden, Jr., 13 Central ave., Newark.
 Henry B. Holler, 291 Verona ave., Newark.
 L. Eugene Hollister, 138 Clinton ave., Newark.
 George J. Holmes, 19 Pennington, Newark.
 William J. Houck, 110 Bloomfield ave., Newark.
 Siegfried Husserl, 273 S. 6th St., Newark.
 Charles L. Ill, 188 Clinton ave., Newark.
 Edward J. Ill, 1002 Broad, Newark.
 Frederick C. Jacobson, 969 Broad, Newark.
 Meyer Jedel, 362 Warren, Newark.
 Jotham C. Johnson, 11 Tichenor, Newark.
 A. R. Judson, Montclair.
 William A. Judson, 235 Clifton ave., Newark.
 Ernest Kaufman, 55 New, Newark.
 William F. Keim, 7 Roseville ave., Newark.
 George R. Kent, 37 Eighth ave., Newark.
 Charles J. Kipp, 560 Broad St., Newark.
 Leroy G. Kirkman, 256 Orange, Newark.
 Joseph M. W. Kitchen, East Orange.
 Maurice I. Klein, 127 Wickliffe, Newark.
 Francis E. Knowles, South Orange.
 Louis A. Koch, 20 Orchard, Newark.
 Henry A. Korneman, 262 15th ave., Newark.
 Geo. F. M. Lamont, 202 Clinton ave., Newark.
 Frank B. Lane, 528 Main St., East Orange.
 Stephen G. Lee, Orange.
 Charles F. Lehlbach, 537 High, Newark.
 Julius Levy, 301 Hunterdon, Newark.
 George Rae Lewis, 481 Summer ave., Newark.
 Samuel B. W. Leyenberger, 98 Third ave., N'rk.
 Jesse D. Lippincott, 304 Summer ave., Newark.
 Frank W. Lockwood, East Orange.
 Arthur A. Loeb, 347 Littleton ave., Newark.
 Herbert W. Long, 102 Jefferson, Newark.
 Andrew J. Loughnan, 136 Bowery, Newark.
 Thomas W. Loweree, 30 Hill, Newark.
 James H. Lowrey 79 Congress, Newark.
 Otto Lowy, 62 Beacon, Newark.
 Calista V. Luther, South Orange.
 Augusta M. Madison-Keim, 188 Roseville ave., N.
 James M. Maghee, 7 Main St., W. Orange.
 Carlo Martinetti, 139 Centre, Orange.
 William H. Martland, 1138 Broad, Newark.
 Henry E. Matthews, 12 Hillside, Orange.
 Daniel L. McCormick, 253 Mulberry, Newark.
 Henry D. McCormick, Verona.
 Floy McEwen, 299 Belleville ave., Newark.
 William H. McKenzie, 942 Broad, Newark.
 Sarah R. Mead, 16 James, Newark.
 Frank B. Meeker, 63 First St., Newark,

ESSEX COUNTY.—Continued.

Panerazio, M. Megaro, 313 High, Newark.
 Paul E. Menk, 29 13th ave., Newark.
 Elizabeth Mercelis, Montclair.
 Charles F. Merrill, 297 Central, Newark.
 Edward M. Merrins, 29 William St., E. Orange.
 Andrew M. Mills, 122 Washington, Newark.
 Augustus J. Mitchell, 74 South, Newark.
 Winthrop D. Mitchell, East Orange.
 John D. Moore, Bloomfield.
 Clement Morris, 75 Washington ave., Newark.
 John B. Morrison, 97 Halsey St., Newark.
 Eugene W. Murray, 493 Summer ave., Newark.
 Samuel A. Muta, Park ave., West Orange.
 Frederick C. Nadler, 31 Green, Newark.
 Albert B. Nash, 10 So. 13th, Newark.
 Clifford R. Neare, 2 Hawthorne, East Orange.
 Emanuel D. Newman, 81 New, Newark.
 Anne B. Newton, South Orange.
 Richard C. Newton, Montclair.
 Willis C. Noble, Montclair.
 Henry W. Nolte, 255 Mulberry, Newark.
 Ralph Opdike, Montclair.
 Peter Parsonette, 132 W. Kinney St., Newark.
 Frederick M. Paul, 562 High St., Newark.
 Edward E. Peck, Caldwell.
 Percy S. Pelouze, 671 Springfield ave., Newark.
 William Pennington, Basking Ridge.
 William Petry, 325 So. Orange ave., Newark.
 E. S. Phelan, 18 South St., Newark.
 George P. Philhower, Nutley.
 Charles R. Pittenger, 82 Congress, Newark.
 D. W. Poor, 27 Ridge St., Orange.
 Katherine Porter, Orange.
 Palmer A. Potter, East Orange.
 Robert C. Potter, 34 Centre, Newark.
 Nathaniel G. Price, 62 Boston, Newark.
 Henry A. Pulsford, South Orange.
 William O'G. Quinby, 80 Columbia, Newark.
 Charles H. Randall, 50 3d ave., Newark.
 Briscoe B. Ranson, Jr., Maplewood.
 Joshua W. Read, 82 Park Pl., Newark.
 R. C. Ribbans, 63 Central ave., Newark.
 Edward M. Richman, 252 Mulberry, Newark.
 Philip Ricord, 268 Bank, Newark.
 Edwin N. Riggins, 225 Midland ave., E. Orange.
 Samuel E. Robertson, 21 Walnut, Newark.
 Benjamin D. Robinson, 265 Mulberry, Newark.
 Manning N. Robinson, 159 Elm, Newark.
 William D. Robinson, East Orange.
 Hugh P. Roden, 345 Washington, Newark.
 William J. Roeber, 24 Monmouth, Newark.
 George A. Rogers, 1 Wallace, Newark.
 Robert H. Rogers, 64 S. 10th, Newark.
 William Rosensohn, 310 Dodd, East Orange.
 Mefford Runyon, South Orange.
 Anthony B. Russell, East Orange.
 Harry A. Scheppach, 164 Bergen St., Newark.
 Charles A. Schneider, 44 Hillside Pl., Newark.
 William A. Schopfer, 43 Read, Newark.
 Charles A. Schureman, 22 Hill, Newark.
 Emanuel Schwarz, 561 High, Newark.
 Edward Sealy, 369 Washington, Newark.
 Edgar C. Seibert, 436 Main, Orange.
 William F. Seidler, 21 Ferry, Newark.
 Marcus Seidman, 580 High, Newark.
 Summer Shailer, 271 Clinton ave., Newark.
 Frederick G. Shaul, Bloomfield.
 Elbert S. Sherman, 191 Summer ave., Newark.
 William F. Shick, 31 Park, Newark.
 M. Herbert Simmons, Orange.
 Daniel M. Skinner, Belleville.
 Anna L. Smith, 201 Walnut, Newark.
 Leonard H. Smith, 6 North Munn ave., E. Ornge.
 D. Winans Smith, 201 Walnut, Newark.
 Edward W. Sprague, 108 Washington St., N'wark.
 Edward Staehlin, 493 High, Newark.
 Jacob S. Stage, 95 Jefferson, Newark.
 R. G. Stanwood, 117 N. 6th, Newark.
 Edwin Steiner, 1 Sterling, Newark.
 Carl E. Sutphen, 181 Roseville ave., Newark.
 Edward B. Sutphen, 997 Broad, Newark.
 Theron Y. Sutphen, 997 Broad, Newark.
 Martin J. Synnott, Montclair.
 Henry A. Tarbell, 28½ Thomas, Newark.
 Charles E. Teeter, 418 Orange, Newark.
 Theodor Teimer, 450 High, Newark.
 F. J. E. Tetreault, Orange.
 Charles W. Titus, 126 N. 7th, Newark.
 Henry A. Towle, 16 Halsey, Newark.
 James H. Trainor, 131 Elm, Newark.
 Ernest Tutschulte, 149 Polk, Newark.
 Sidney A. Twinch, 598 Broad, Newark.
 Charles F. Underwood, 259 Mt. Prospect ave., N.
 Herbert B. Vail, Belleville.
 Sarah E. Van Duyn, 247 Belleville ave., Newark.
 Benj. S. Van Dyke, 101 Eaton Pl., East Orange.
 George A. Van Wagenen, 101 N. 6th, Newark.
 Maria M. Vinton, East Orange.
 Benjamin H. Voelbel, Vailsburgh.
 George N. Waite, 569 High, Newark.
 Henry Wallace, Glen Ridge.
 Henry J. F. Wallhauser, 47 New, Newark.
 Edwin M. Ward, Bloomfield.
 Gertrude P. Ward, Bloomfield.
 William J. Ward, 438 Warren, Newark.
 W. H. Alonzo Warner, 400 Central ave., E. Or.
 George L. Warren, 77 Houston, Newark.
 W. H. Warren, 181 Verona ave., Newark.
 Walter S. Washington, 8 Washington Pl., N'wark.
 Frederick C. Webner, 96 Clinton avenue., Newark.
 Louis Weiss, 227 So. Orange ave., Newark.
 G. O. Welshman, 150 Summer ave., Newark.
 Elmer G. Wherry, 325 Clinton ave., Newark.
 William H. White, Bloomfield.
 Henry B. Whitehorse, Verona.
 M. Royal Whitenack, 19 Bathgate Pl., Newark.
 Albert Wickman, 325 Washington, Newark.
 W. Stockton Wilson, 96 Montclair ave., Newark.
 Joseph C. Winans, St. Michael's Hospital, N'k.
 Edward E. Worl, 271 High, Newark.
 James A. Wormley, 83 New, Newark.
 Fred J. Wort, Jr., 184 Clinton ave., Newark.
 James T. Wrightson, 25 Walnut, Newark.
 Charles Young, 23 E. Kinney, Newark.
 Joseph C. Young, 964 Broad, Newark.
 Number Members, 291.

GLOUCESTER COUNTY.

Society organized December, 1818. Annual meeting third Thursday in January.

C. Frank Fisler, *Pres.*, Clayton.
 M. Jones Luffbary, *Vice-Pres.*, Glassboro.
 Geo. E. Reading, *Sec'y. and Treas.*, Woodbury.
 Wesley Grant Simunons, *Rep.*, Swedesboro.
 L. M. Halsey, *Censor*, Williamstown.
 James Hunter, Jr., *Censor*, Westville.
 Harry A. Stout, *Censor*, Wenonah.
 Samuel F. Ashcraft, Mullica Hill.

GLOUCESTER COUNTY—Continued.

William Brewer, Woodbury.
 Henry B. Diverty, Woodbury.
 Elias M. Duffield, Glassboro.
 J. Gaunt Edwards, Williamstown.
 T. Franklin Gifford, Woodbury.
 Chas. S. Heritage, Glassboro.
 Eugene Z. Hillegas, Mantau.
 George C. Laws, Paulsboro.
 James C. McClure, Williamstown.
 B. Frank Ogden, Clayton.
 Eugene T. Oliphant, Bridgeport.
 Cyrus B. Phillips, Hurffville.
 U. S. Grant Sparks, Mantua.

Samuel F. Stanger, Harrisonville.
 P. E. Stilwagon, Bridgeport.
 William M. Stratton, Woodbury.
 Howard A. Wilson, Woodbury.
HONORARY MEMBERS.
 George W. Bailey, Philadelphia, Pa.
 Judson Daland, Philadelphia, Pa.
 E. E. DeGrofft, Woodstown.
 Hobart A. Hare, Philadelphia, Pa.
 William H. Iszard, Camden.
 Charles P. Noble, Philadelphia, Pa.
 Chas. S. Turnbull, 1935 Chestnut, Phila., Pa.
 Number Members, 25.

HUDSON COUNTY.

Organized October 1, 1851. Annual Meeting first Tuesday in April.

Frank D. Gray, *Pres.*, 79 Summit ave., Jersey City.
 Henry Spence, *Vice-Pres.*, 681 Bergen ave., J. C.
 August A. Strasser, *Rep.*, 115 Beach, Arlington.
 Louis W. Dodson, *Sec'y.*, 660 Jersey ave., J. City.
 Henry H. Brinkerhoff, *Treas.*, 695 Bergen ave., Jersey City.
 Fred M. Corwin, *Censor*, 7 W. 6th, Bayonne.
 John C. Parsons, *Censor*, 311 York, Jersey City.
 W. Perry Watson, *Censor*, 35 Bentley ave., Jer. C.
 Henry D. Abbott, 24 East 33d St., Bayonne.
 Ulamor Allen 235 Ogden ave., Jersey City.
 Elmer H. Ames, 17 Madison ave., Jersey City.
 Henry Allers, 109 Harrison ave., Harrison.
 William J. Arlitz, 630 Bloomfield, Hoboken.
 Edward C. Armstrong, 512 Fulton, Town of Union.
 E. Mills Baker, 103 Wayne, Jersey City.
 John J. Baumann, 661 Jersey ave., Jersey City.
 Louis Baumann, 250 5th, Jersey City.
 Oliver R. Blanchard, 37 Clinton ave., Jersey City.
 Henry J. Bogardus, 427 Bergen ave., Jersey City.
 J. G. Lewis Borgmeyer, 90 W. 8th, Bayonne.
 Frank F. Bowyer, Barrow st., Jersey City.
 William W. Brooke, 915 Ave. C, Bayonne.
 John J. Broderick, 355 Pacific ave., Jersey City.
 Edward L. Bull, 2 Madison ave., Jersey City.
 Henry H. Burnett, 724 Washington, Hoboken.
 Talbot R. Chambers, 15 Exchange Pl., Jersey City.
 John A. Chard, 14 Virginia ave., Jersey City.
 Frank M. Childs, 927 Washington, Hoboken.
 Charles B. Converse, 218 Palisade ave., Jer. City.
 Burdette P. Craig, Blvd & Highland ave., Jer. C.
 C. W. Crankshaw, 235 North 7th, Newark.
 Charles W. Cropper, 85 Gifford ave., Jersey City.
 D. LeRoy Culver, 287 York, Jersey City.
 George M. Culver, 49 Tonnelle ave., Jersey City.
 S. Herbert Culver, 98 Magnolia ave., Jersey City.
 Alexander Dallas, 24 E. 22nd, Bayonne.
 Clara M. DeHart, 99 Mercer, Jersey City.
 Charles L. DeMerritt, 302 Shippin, Hoboken.
 Gordon K. Dickinson, 278 Montgomery, Jer. City.
 R. H. Dinglestedt, 619 Hudson, Hoboken.
 M. O. F. Dolphin, 112 4th, Harrison.
 Lucius F. Donahue, 33 Dodge, Bayonne.
 Edwin K. Dunkel, 264 Montgomery, Jersey City.
 James G. Enright, 207 York, Jersey City.
 Chauncey V. Everitt, 38 Boyd ave., Jersey City.
 John R. Everitt, 38 Boyd ave., Jersey City.
 James A. Exton, 75 Beach, Arlington.
 John Faber, 289 Central ave., Jersey City.
 William F. Faison, 490 Jersey ave., Jersey City.
 J. C. Farr, Jr., 1233 Garden, Hoboken.
 Charles H. Finke, 315 York, Jersey City.
 J. Frederick Finn, 157 Danforth ave., Jersey City.

Joseph F. Finn, 157 Danforth ave., Jersey City.
 Michael F. Foley, 710 Hudson, Hoboken.
 Joseph L. Fopeano, 265 4th, Hoboken.
 Archibald C. Forman, 41 W. 32nd, Bayonne.
 Howard S. Forman, 103 Jewett ave., Jersey City.
 P. W. Frace, 106 11th, Hoboken.
 L. Franklin, 125 Palisade ave., Jersey City.
 Aaron Freidman, 112 Park ave., Hoboken.
 William Friele, 203 Palisade ave., Jersey City.
 George D. Fyfe, 540 Bramhall ave., Jersey City.
 E. Gamson, 41 W. 24th, Bayonne.
 R. W. Gelbach, 809 Hudson, Hoboken.
 Charles A. Gilchrist, 916 Hudson, Hoboken.
 Hugo Gillé, 149 Congress, Jersey City.
 Robert B. Gilman, 85 Congress, Jersey City.
 E. H. Goldberg, 238 Kearny ave., Kearny.
 Daniel S. Hardenberg, 354 Pacific ave., Jer. City.
 Edward P. Hart, 316 Montgomery, Jersey City.
 Arthur P. Haskings, 318 Montgomery, Jer. City.
 Max Hecht, 324 Shippin, West Hoboken.
 Bert. S. Heintzelmann, 43 W. 33d, Hoboken.
 Samuel A. Helfer, 626 Hudson, Hoboken.
 William L. Hetherington, 299 Varick, Jersey City.
 Christopher S. Hill, 102 Grand, Jersey City.
 Charles E. Hoening, 606 Hudson, Hoboken.
 Peter Hoffman, 209 Pavonia ave., Jersey City.
 T. J. Jacquemin, 192 Bergenline ave., Union Hill.
 J. Eugene Jacques, 74 Waverly, Jersey City.
 Walter A. Jaquith, Broad and Market, Newark.
 J. Morgan Jones, 121 Sip ave., Jersey City.
 Thomas J. Keegan, 838 Grand, Jersey City.
 A. John Kirsten, 287 Varick, Jersey City.
 Calvin F. Kyte, Garrison and Sip ave., Jer. City.
 William L. Kudlich, 408 Hudson, Hoboken.
 Richard Kuehne, 1118 Summit ave., Jersey City.
 Frederick W. Lambert, 157 Ocean ave., Jer. City.
 Mortimer Lampson, 322 Pacific ave., Jersey City.
 Charles A. Limeburner, 79 Danforth ave., Jer. C.
 Frank W. Mallalieu, 62 Monticello ave., Jer. City.
 Edward G. Marks, Elshermius, Arlington.
 W. J. Matthews, 1009 Garden, Hoboken.
 John D. McGill, 124 Mercer, Jersey City.
 William B. McGlenon, 310 Central ave., E. New.
 George E. McLaughlin, 41 Crescent ave., Jer. C.
 John J. McLean, 430 Hoboken ave., Jersey City.
 Thomas J. McLoughlin, 558 Jersey ave., Jer. City.
 Thomas C. McNamara, 715 Park ave., Hoboken.
 W. Meyer, 446 Clinton ave., West Hoboken.
 John J. Mooney, 554 Jersey ave., Jersey City.
 Edward Mulvaney, 487 Jersey ave., Jersey City.
 George W. Muttart, 702 Ocean ave., Jersey City.
 David I. Nalitt, 22 East 22nd, Bayonne.
 A. Nelson, 105 Grand, Jersey City.

HUDSON COUNTY.—Continued.

John Nevin, Boul. and Kensington ave., J. City.
 J. F. O'Connor, 35 Kearny ave., Kearny.
 August W. Oestman, 961 Summit ave., Jer. City.
 T. Richard Paganelli, 401 Monroe, Hoboken.
 William J. Parker, 694 Bergen ave., Jersey City.
 Luigi Pezzè, 280 4th, Jersey City.
 David S. Pinder, 201 Garden, Hoboken.
 Abdon V. Piskorski, 261 5th St., Jersey City.
 B. S. Pollak, 241 Grove, Jersey City.
 Louis Poole, 521 Palisade ave., West Hoboken.
 Charles H. Purdy, 312 Montgomery, Jersey City.
 Imanuel Pyle, 54 Monticello ave., Jersey City.
 Wallace Pyle, 713 Bergen, Jersey City.
 Murray E. Ramsey, 402 Arlington ave., Jer. City.
 Joseph M. Rector, 307 York, Jersey City.
 S. A. Reich, 118 Bowers, Jersey City.
 James H. Rosenkrans, 826 Hudson, Hoboken.
 A. J. Rosenstein, 139 Wayne, Jersey City.
 Norman L. Rowe, 798 Grand, Jersey City.
 Henry B. Rue, 931 Fairfield, Hoboken.
 Ferdinand W. Sauer, 314 Varick, Jersey City.
 Richard Schlemm, 116 Palisade ave., T. of Union.
 Geo. H. Sexsmith, 719 Ave. C, Bayonne.
 L. H. Sheiner, Bergenline ave., opp. Niles ave.,
 Town of Union.
 George W. Shera, 489 Jersey ave., Jersey City.
 Manning F. Squier, 234 Harrison ave., Harrison.
 Eban T. Steadman, 635 Washington, Hoboken.
 Walter Steadman, 213 Garden, Hoboken.
 Frank D. Stellwagon, 530 Union Pl., T. of Union.
 Pliney F. Stevens, 950 Avenue C, Bayonne.
 Robert Stewart, 824 Grand, Jersey City.
 S. Henry Sulouff, 10 W. Hamilton Pl., Jer. City.
 M. A. Swiney, 283 Avenue C, Bayonne.
 H. T. Van Deestin, 619 Garden, Hoboken.
 Clarence M. Vreeland, 174 Ocean ave., Jer. City.
 Hamilton Vreeland, 78 Summit ave., Jersey City.
 William Vreeland, 2 Park, Jersey City.
 A. John Walschied, 309 Fulton, Town of Union.
 James W. Ware, Ave. C and 46th, Bayonne.
 Otto A. Weigand, 1151 Summit ave., Jersey City.
 Henry E. Woelfle, 75 Bowers, Jersey City.
 F. C. Wolff, 1136 Garden, Hoboken.
 Joseph Wolfson, 302 Montgomery, Jersey City.
 Stanley R. Woodruff, 22 W. 22d, Bayonne.
 Number members, 149.

HUNTERDON COUNTY.

Society organized June 12, 1821. Annual meeting fourth Tuesday in April.

Morris H. Leaver, *Pres.*, Quakertown.
 Louis C. Williams, *First Vice-Pres.*, Lambertville.
 Theo. B. Fulper, *Second Vice-Pres.*, Junction.
 Obadiah H. Sproul, *Sec'y*, Flemington.
 Isaac S. Cramer, *Treas.*, Flemington.
 Leon T. Salmon, *Rep.*, Lambertville.
 Geo. W. Bartow, *Censor*, Three Bridges.
 Willard E. Berkaw, *Censor*, Annandale.
 Geo. L. Romine, *Censor*, Lambertville.
 Edgar Allen, Pattenburg.
 Ernest E. Banker, Three Bridges.
 Enoch Blackwell, Clinton.
 George N. Best, Rosemont.
 Wm. R. Carpenter, Mt. Pleasant.
 John L. Chamberlin, Milford.
 Edward Clossen, Lambertville.
 Wm. S. Creveling, Valley.
 Frederick W. Decker, Frenchtown.
 John H. Ewing, Flemington.
 Francis S. Grim, Baptistown.
 Fred L. Johnson, Stanton.
 Edward D. Leidy, Flemington.
 Alfred B. Nash, Frenchtown.
 William H. Schenck, Flemington.
 Peter C. Young, Ringoes.
 HONORARY MEMBERS.
 H. P. Loomis, New York City.
 W. D. Wolverton, U. S. Army, Retired.
 Number members, 25.

MERCER COUNTY.

Society organized May 23, 1848. Annual meeting second Tuesday in May.

David B. Ackley, *Pres.*, 881 E. State, Trenton.
 David F. Weeks, *V. Pres.*, 326 W. State, Trenton.
 James J. McGuire, *Sec'y*, 330 S. Broad, Trenton.
 Ira M. Shepherd, *Treas.*, 188 S. Broad, Trenton.
 Chas. H. Mitchell, *Rep.*, 116 Centre, Trenton.
 Chas. F. Adams, 52 W. State, Trenton.
 Chas. L. Allen, P. O. Box 258, Trenton.
 Alex. Armstrong, 323 S. Broad, Trenton.
 Arthur M. Barrows, 300 S. Clinton, Trenton.
 Elmer Barwis, 211 Hamilton ave., Trenton.
 Henry M. Beatty, 50 Centre, Trenton.
 Chas. P. Britton, 126 W. State, Trenton.
 John Bruyere, 123 Perry, Trenton.
 Frank V. Cantwell, 78 N. Clinton ave., Trenton.
 W. A. Clark, 51 W. State, Trenton.
 W. S. Collier, 723 S. Broad, Trenton.
 J. C. Craythorn, 302 W. State, Trenton.
 Paul L. Cort, 144 W. State, Trenton.
 Henry B. Costill, 506 E. State, Trenton.
 A. H. Dey, 430 E. State, Trenton.
 Ernest L. Dickinson, 100 Greenwood ave., Trenton.
 William Elmer, 44 W. State, Trenton.
 E. K. Fee, Lawrenceville.
 J. C. Felty, P. O. Box 258, Trenton.
 Geo. H. Franklin, Hightstown.
 Edward B. Funkhauser, P. O. Box 258, Trenton.
 C. H. Gordon, 930 E. State, Trenton.
 E. J. Gordon, 925 Clinton, Trenton.
 W. J. Harmon, 1162 E. State, Trenton.
 Frank Harris, 214 N. Warren, Trenton.
 E. S. Hawke, 124 E. Hanover, Trenton.
 Chas. H. Holcombe, 41 W. State, Trenton.
 A. Dunbar Hutchinson, 419 Chestnut ave., Tren'n.
 Mozart Jenkins, 136 Walnut ave., Trenton.
 William S. Lalor, 220 N. Warren, Trenton.
 Thos. H. McKenzie, 528 E. State, Trenton.
 Walter Madden, 324 S. Broad, Trenton.
 Thaddeus P. Martin, 46 Spring, Trenton.
 Geo. R. Moore, 259 Hamilton ave., Trenton.
 H. G. Norton, 429 E. State, Trenton.
 Harry R. North, 284 Hamilton ave., Trenton.
 N. B. Oliphant, 152 W. State, Trenton.
 Geo. H. Parker, 420 E. State, Trenton.
 L. A. Pierson, Hopewell.
 C. H. Read, S. Warren and Fall, Trenton.
 Martin W. Reddan, 113 W. State, Trenton.
 Geo. M. Ridgeway, 140 W. State, Trenton.
 Elmer H. Rogers, 126 N. Warren, Trenton.

MERCER COUNTY—Continued.

R. R. Rogers, 110 E. Hanover, Trenton.
 R. R. Rogers, Jr., 610 Perry, Trenton.
 Wm. C. Sandy, P. O. Box 258, Trenton.
 G. Schoening, 223 Perry, Trenton.
 J. B. Seeds, 495 Centre, Trenton.
 Jos. B. Shaw, 119 S. Warren, Trenton.
 Houghton Smith, 1007 Division, Trenton.
 Geo. N. J. Sommers, 229 Perry, Trenton.
 W. D. Stevenson, 40 S. Clinton ave., Trenton.
 Geo. E. Titus, Hightstown.
 John W. Ward, P. O. Box 258, Trenton.

David Warman, 239 Chestnut ave., Trenton.
 Chas. H. Waters, 50 W. Hanover, Trenton.
 Jos. M. Wells, 922 Edgewood ave., Trenton.
 E. L. West, St. Francis Hospital, Trenton.
 James Holmes Wikoff, Princeton.
 Wm. J. Wilbur, "Aleda," Hanover St., Trenton.
 P. W. Yard, 727 S. Broad, Trenton.

HONORARY MEMBERS.

Joseph K. Young, 222 S. 16th, Philadelphia, Pa.
 Number members, 66.

MIDDLESEX COUNTY.

Society organized June 16, 1816. Annual meeting third Wednesday in April.

Henry H. Janeway, *Pres.*, 11 Living'n ave., N. B.
 Edgar Carroll, *V. Pres.*, Main, Dayton.
 Alfred L. Ellis, *Sec'y*, Main, Metuchen.
 David C. English, *Treas.*, 363 George, New Brun.
 Arthur L. Smith, *Rep.*, 62 Bayard, New Brunsw'k.
 John C. Albright, 194 Broadway, South Amboy.
 Thomas Alsop,
 John J. Bissett, Main, South River.
 Charles V. Buttler, 139 Albany, New Brunswick.
 A. Schuyler Clark, 531 Madison ave., New York.
 S. V. D. Clark, 89 Bayard, New Brunswick.
 William J. Condon, 336 George, New Brunswick.
 Frank M. Donohue, 139 Albany, New Brunswick.
 Laurence D. Doyle, Woodbridge.
 George W. Fithian, 195 High, Perth Amboy.
 Herman D. Gross, Main, Metuchen.
 Benj. Gutmann, 418 George, New Brunswick.
 Edward E. Haines, 134 David, South Amboy.
 Frank C. Henry, 134 State, Perth Amboy.
 A. Clark Hunt, Holly, Metuchen.
 John L. Lund, 181 High, Perth Amboy.
 Eugene A. Meacham, 120 David, South Amboy.

William M. Moore, 79 Livingston ave., N. Bruns.
 Daniel L. Morrison, Elm Row and Pats'n, N. B.
 William E. Ramsey, 193 High, Perth Amboy.
 J. Warren Rice, 304 George, New Brunswick.
 Ferdinand E. Riva, Main and Riva ave., Milltown.
 Patrick A. Shannon, 133 Albany, New Brunswick.
 Charles Silk, 422 State, Perth Amboy.
 Clarence M. Slack, 50 Livingston ave., N. Bruns.
 Ira T. Spencer, Main, Woodbridge.
 David Stephens, 229 George, New Brunswick.
 John L. Suydam, Jamesburg.
 Henry C. Symmes, Cranbury.
 Ambrose Treganowan, Main, South Amboy.
 George W. Tyrrell, 222 State, Perth Amboy.
 J. Leon White, Main, South Amboy.
 John G. Wilson, 186 High, Perth Amboy.
 A. L. Woods, Main, South River.

HONORARY MEMBERS.

Henry G. Cooke, 7 Livingston ave., New Bruns.
 John C. Holmes, Cranbury.
 Number members, 39.

MONMOUTH COUNTY.

Society organized June 16, 1816. Annual meeting second Tuesday in December.

William B. Warner, *Pres.*, Red Bank.
 Harry E. Shaw, *V. Pres.*, Long Branch.
 D. McLean Forman, *Sec'y*, Freehold.
 I. S. Long, *Treas.*, Freehold.
 Harry B. Slocum, *Rep.*, Long Branch.
 A. T. Applegate, Englishtown.
 George H. Baker, Long Branch.
 E. M. Beach, West Long Branch.
 John W. Bennett, Long Branch.
 R. S. Bennett, Asbury Park.
 William W. Beveridge, Asbury Park.
 Harvey S. Brown, Freehold.
 W. R. Campbell, Long Branch.
 Henry G. Cook, New Brunswick.
 Ellis W. Crater, Ocean Port.
 V. M. Disbrow, Lakewood.
 Edwin Field, Red Bank.
 Walter P. Havens, Farmingdale.
 William M. Hepburn, Freehold.
 Daniel D. Hendrickson, Middletown.
 H. A. Hendrickson, Atlantic Highlands.
 G. C. Hoagland, Keyport.
 Harry W. Ingling, Freehold.

A. J. Jackson, Matawan.
 Samuel Johnson, Asbury Park.
 W. R. Kinmouth, Farmingdale.
 Cyrus Knecht, Matawan.
 S. R. Knight, Spring Lake.
 Henry Mitchell, Asbury Park.
 R. T. Partree, Eatontown.
 F. C. Price, Imlaystown.
 P. J. Rafferty, Red Bank.
 James J. Read, Sea Bright.
 Edgar Roberts, Keyport.
 John Taylor, Ocean Grove.
 Charles H. Thompson, Belmar.
 James B. Wainwright, Manasquan.
 Joseph T. Welch, Long Branch.
 Walter S. Whitmore, Red Bank.
 George F. Wilbur, Asbury Park.
 Scudder J. Woolley, Long Branch.

HONORARY MEMBERS.

George T. Welch, Passaic.
 Number members, 41.

MORRIS COUNTY.

Society organized June 1, 1815. Annual meeting second Tuesday in March.

W. J. Wolfe, *Pres.*, Chatham.
 G. H. Foster, *V. Pres.*, Rockaway.

H. W. Kice, *Sec'y*, Wharton.
 James Douglas, *Treas.*, Morristown.

MORRIS COUNTY.—Continued.

H. S. Wheeler, *Rep.*, Whippany.
 N. H. Adsit, Succasunna.
 Calvin Anderson, Madison.
 R. D. Baker, Morris Plains.
 Theodore W. Bebout, Stirling.
 G. A. Becker, Morristown.
 C. C. Beling, Morris Plains.
 A. E. Carpenter, Boonton.
 Alexander J. Carroll, Morris Plains.
 Emma C. Clark, Dover.
 A. W. Condict, Dover.
 Harry A. Cossitt, Morris Plains.
 E. P. Cooper, Parsippany.
 R. L. Cook, Dover.
 A. B. Coultas, Madison.
 T. R. Crittenden, Dover.
 H. V. Day, Bloomingdale.
 Clinton L. Decker, Boonton.
 G. S. DeGroot, Mendham.
 Lancelot Ely, Flanders.
 Britton D. Evans, Morris Plains.
 J. Willard Farrow, Dover.
 Levi Farrow, Hackensack.
 F. W. Flagge, Rockaway.
 Francis H. Glazebrook, Morristown.
 Eliot Gorton, Summit.
 James B. Griswold, Morristown.
 Samuel C. Haven, Morristown.
 H. A. Henriques, Morristown.

Fred. C. Horsford, Morris Plains.
 George L. Johnson, Morristown.
 Alfred A. Lewis, Morristown.
 Amasa A. Macwithey, Riverdale.
 Peter S. Mallon, Morris Plains.
 L. L. Mial, Morristown.
 Clifford Mills, Morristown.
 Harrie M. Reilly, Morristown.
 Fred. Wooster Owen, Morristown.
 Stephen Pierson, Morristown.
 Joseph E. Pollard, Chatham.
 J. Boyd Risk, Summit.
 J. G. Ryerson, Boonton.
 Frederick L. Seward, Madison.
 M. S. Simpson, Middle Valley.
 E. Sutton, German Valley.
 John L. Taylor, Boonton.
 Harry Vaughan, Morristown.
 John Walters, Wharton.
 Cuthbert Wigg, Boonton.
 George W. V. Wilkinson, Morristown.

HONORARY MEMBERS.

I. W. Condict, Dover.
 P. A. Harris, Paterson.

ASSOCIATE MEMBERS.

Louis F. Bishop, New York.
 Thomas P. Prout, New York.
 Number members, 54.

OCEAN COUNTY.

Society organized October 28, 1903. Annual meeting first Wednesday in April.

Irwin H. Hance, *Pres.*, Lakewood.
 Ralph R. Jones, *V. Pres.*, Toms River.
 Alexander M. Heron, *Sec'y*, Lakewood.
 Harold Pittis, *Treas.*, Lakehurst.
 William Gray Schaffler, *Rep.*, Lakewood.
 Frank Brouwer, Toms River.
 Frederick S. Buckingham, Lakewood.
 Eugene E. S. Carrigan, Point Pleasant.

Edwin C. Disbrow, Toms River.
 Rem Lefferts Disbrow, Toms River.
 Vanderhoef M. Disbrow, Lakewood.
 Paul T. Kimball, Lakewood.
 C. L. Lindley, Lakewood.
 George W. Mac Millan, Lakewood.

Number members, 14.

PASSAIC COUNTY.

Society organized January 14, 1844. Meets second Tuesday in each month, except July, August and September.
 Annual meeting second Tuesday in April.

F. F. C. Demarest, *Pres.*, 29 Academy, Passaic.
 John T. Gillson, *V. Pres.*, 391 Main, Paterson.
 E. J. Marsh, Jr., *Sec'y*, 24 Church, Paterson.
 George E. Tuers, *Treas.*, 12 Church, Paterson.
 E. L. Henion, *Rep.*, 16 Church, Paterson.
 M. A. Mackintosh, *Censor*, 267 Ellison, Paterson.
 M. W. Gillson, *Censor*, 11 Lee Pl., Paterson.
 J. W. Atkinson, *Censor*, 27 Church, Paterson.
 F. E. Agnew, 29 Hamilton, Paterson.
 A. F. Alexander, 379 Union ave., Paterson.
 George H. Balleray, 115 Broadway, Paterson.
 John H. Banta, 119 Broadway, Paterson.
 Joseph V. Bergin, 19 Church, Paterson.
 William Blundell, 236 Main, Paterson.
 David T. Bowden, 117 Paterson St., Paterson.
 James F. Briody, 385 Main, Paterson.
 J. Alex. Browne, 310 Grand, Paterson.
 V. E. Bullen, 156 Broadway, Paterson.
 Charles M. Campbell, 642 Main, Paterson.
 William H. Carroll, 11 Jefferson, Passaic.
 W. E. Chase, 185 Main ave., Passaic.
 David R. Crounse, 84 Bloomfield ave., Passaic.
 James H. Curtis, 30 Church, Paterson.
 R. M. Curtis, 30 Church, Paterson.

George S. Davenport, Garfield.
 Simon DeJager, 83 Bridge, Paterson.
 Edward F. Denner, 221 Broadway, Paterson.
 Frank B. Donohue, 389 Main, Paterson.
 Owsley B. Duncan, Haledon.
 Walter L. Dunning, 533 River, Paterson.
 George Fischer, 90 Auburn, Paterson.
 William Fliteroft, 510 River, Paterson.
 G. Balleray Flood, 115 Broadway, Paterson.
 William S. Green, 73 Paterson, Paterson.
 Philander A. Harris, 26 Church, Paterson.
 J. H. Henggeler, 47 Bridge, Paterson.
 William H. Jacob, 95 N. Main, Paterson.
 Walter B. Johnson, 170 Broadway, Paterson.
 Charles J. Kane, 349 Grand, Paterson.
 Thomas J. Kane, 349 Grand, Paterson.
 F. J. Keller, 379 Totowa ave., Paterson.
 Henry Kip, 90 Fair, Paterson.
 John L. Leal, 661 E. 18th, Paterson.
 H. H. Lucas, 192 Van Houten, Paterson.
 W. Wallace MacAlister, 21 Church St., Paterson.
 Joseph Maclay, 160 Broadway, Paterson.
 Bryan C. Magennis, 81 Bridge, Paterson.
 E. J. Marsh, 600 Park ave., Paterson.

PASSAIC COUNTY—Continued.

A. F. McBride, 397 Main, Paterson.
Caesar P. McClendon, 48 Fair, Paterson.
John C. McCoy, 202 Broadway, Paterson.
Frank McDede, 908 Main, Paterson.
John R. Merrill, 15 Church, Paterson.
Daniel T. Millspough, 43 Totowa ave., Paterson.
James P. Morrill, 10 Church, Paterson.
Rush Neer, 95 Bridge, Paterson.
William Neer, 87 Fair, Paterson.
William K. Newton, 379 Ellison, Paterson.
William A. Norval, 419 Main, Paterson.
James O'Donnell, 82 Ward, Paterson.
T. F. O'Grady, 374 Grand, Paterson.
Henry Parke, 9 Church, Paterson.
J. P. Paxton, 16 Church St., Paterson.
H. V. Pike, 144 Hamilton ave., Paterson.
John J. Ritter, 16 Smith, Paterson.
B. H. Rogers, 213 Broadway, Paterson.
John N. Ryan, 275 Passaic, Passaic.
F. R. Sandt, 466 Park ave., Paterson.

C. H. Scribner, 82 Ward, Paterson.
James M. Stewart, 181 Van Houten, Paterson.
R. Stinson, 158 Broadway, Paterson.
John J. Sullivan, 51 Passaic ave., Passaic.
Isaac Surnamer, 89 Bridge, Paterson.
Joseph Tattersall, 1042 Main, Paterson.
Arthur H. Temple, 164 Jefferson, Passaic.
George W. Terriberry, 146 Broadway, Paterson.
P. H. Terhune, 162 Gregory ave., Passaic.
F. H. Todd, 218 Broadway, Paterson.
Sylvester Utter, 12 Church, Paterson.
A. B. Vanderbeck, 174 Broadway, Paterson.
John Van Ess, 59 Bridge, Paterson.
A. Ward Van Riper, 207 Main ave., Passaic.
C. Van Riper, 207 Main ave., Passaic.
F. Vigna, 35 Ward, Paterson.
George Vreeland, 127 Hamburg ave., Paterson.
John S. Yates, 79 Bridge, Paterson.

Number members, 86.

SALEM COUNTY.

Society organized May 4, 1880. Annual meeting first Wednesday in May.

F. B. Husted, *Pres.*, Quinton.
N. S. Hires, *V. Pres.*, Salem.
Henry Chavanne, *Sec'y and Treas.*, Salem.
L. H. Hummel, *Rep.*, Salem.
F. Bilderback, *Censor*, Salem.
E. E. DeGroot, *Censor*, Woodstown.
W. H. Carpenter, Salem.
R. M. Davis, Salem.
W. L. Ewen, Alloway.
G. W. H. Fitch, Daretown.
Daniel Garrison, Pennsgrove.
W. T. Good, Bridgeton.

F. B. Harris, Canton.
W. H. James, Pennsville.
H. T. Johnson, Pedricktown.
C. M. Sherron, Salem.
John Morris Summerill, Pennsgrove.
John F. Smith, Salem.
B. A. Waddington, Salem.

ASSOCIATE MEMBERS.

W. A. Jaquett, D. D. S., Salem.
Number members, 19.

SOMERSET COUNTY.

Society organized May, 1816. Annual meeting second Tuesday in April.

J. Hervey Buchanan, *Pres.*, North Plainfield.
John B. Beekman, *V. Pres.*, Pluckamin.
William H. Long, Jr., *Sec'y*, Somerville.
Thomas H. Flynn, *Treas.*, Somerville.
Claudis R. P. Fisher, *Rep.*, *Censor*, Bound Brook.
John P. Hecht, *Censor*, Somerville.
Aaron L. Stillwell, *Censor*, Somerville.
Arthur H. Dundon, North Plainfield.
Henry V. Davis, North Branch.
Mary E. Gaston, Somerville.
Fred J. Hughes, North Plainfield.
Josiah Meigh, Bernardsville.
William H. Merrill, South Branch.
Sewell O. B. Taylor, Millstone.

Mahlon C. Smalley, Gladstone.
John F. McWilliam, Somerville.
H. M. Weeks, Skillman.
F. A. Wild, Bound Brook.
Frank B. Zandt, Harlingen.
Peter J. Zeglio, North Plainfield.

HONORARY MEMBERS.

John W. Ward.

ASSOCIATE MEMBERS.

E. R. Voorhees, M. D. C., Somerville.
Number members, 20.

SUSSEX COUNTY.

Society organized August 22, 1829. Annual meeting second Tuesday in May.

Morgan D. Hughes, *Pres.*, Layton.
John Moore, *V. Pres.*, Sussex.
Shepard Voorhees, *Sec'y*, Newton.
E. Morrison, *Treas.*, Newton.
H. D. Van Gaasbeek, *Rep.*, Sussex.
L. C. Burd, Ogdensburg.
Martin Cole, Hainesville.
Joseph G. Coleman, Hamburg.
C. K. Davison, Stanhope.
Charles M. Dunning, Franklin.
B. W. Ferguson, Beemerville.

Bruno Hood, Newton.
Harvey J. McCloughan, Newton.
J. N. Miller, Newton.
J. B. Pellett, Hamburg.
J. C. Price, Branchville.

HONORARY MEMBERS.

T. H. Andress, Sparta.
Joseph Hunt, Huntsville.
Number members, 16.

UNION COUNTY.

Society organized June 7, 1869. Annual meeting second Wednesday in April.

Thomas E. Dolan, *Pres.*, 250 1st ave., Elizabeth.
 Horace R. Livengood, *V. Pres.*, 1105 E. Jersey St., Elizabeth.
 P. DuBois Bunting, *Sec'y.*, 11 3d, Elizabeth.
 Alvin R. Eaton, Jr., *Treas.*, 1157 E. Jersey St., Elizabeth.
 Milton A. Shangle, *Rep.*, 1148 E. Jersey, Elizabeth.
 Ellis W. Hedges, *Censor*, Plainfield.
 Thomas N. McLean, *Censor*, 1144 E. Broad, Eliz.
 Norton L. Wilson, *Censor*, 410 Westminster ave., Elizabeth.
 F. C. Ard, Plainfield.
 Frederick R. Bailey, 1165 E. Jersey, Elizabeth.
 Pierre A. Banker, 1156 E. Jersey, Elizabeth.
 William M. Barnes, Springfield.
 William C. Boone, Plainfield.
 Thomas F. Burnett, 249 Court, Elizabeth.
 John H. Carman, Plainfield.
 W. E. Cladek, Rahway.
 Marcus L. Clawson, Plainfield.
 J. Ackerman Coles, Scotch Plains.
 J. H. P. Conover, 1143 E. Jersey, Elizabeth.
 Peter B. Cregar, Plainfield.
 N. W. Currie, Plainfield.
 Reuben B. Dearborn, 1028 E. Jersey, Elizabeth.
 Alfred Q. Donovan, 132 E. Jersey, Elizabeth.
 George W. Endicott, Plainfield.
 J. T. Fritts, Plainfield.
 Joseph Funk, 615 Elizabeth ave., Elizabeth.
 W. F. Gaston, Plainfield.
 James S. Green, 463 N. Broad, Elizabeth.
 Edgar B. Grier, 1145 E. Jersey, Elizabeth.
 J. B. Harrison, Westfield.
 B. Van D. Hedges, Plainfield.
 B. W. Hoagland, Woodbridge.
 H. Page Hough, Rahway.
 Stephen J. Keefe, 1063 E. Jersey, Elizabeth.
 J. Herbert Keenan, 22 W. Jersey, Elizabeth.
 F. A. Kinch, Westfield.
 Samuel Korngut, 116 Bond, Elizabeth.
 George S. Laird, Westfield.

Alfred Lawrence, 1086 Elizabeth ave., Elizabeth.
 Theodore F. Livengood, 1105 E. Jersey, Elizabeth.
 Monroe D. Long, Plainfield.
 J. K. McConnell, Cranford.
 Robert R. Montfort, 1051 E. Jersey, Elizabeth.
 William H. Murray, Plainfield.
 Dennis McElhinney, 626 Elizabeth ave., Elizabeth.
 Victor Mravlag, 1062 E. Jersey, Elizabeth.
 Edward R. O'Reilly, 167 Second, Elizabeth.
 Albert Pettis, Plainfield.
 Alonzo Pettit, 116 W. Grand, Elizabeth.
 James L. Perkins, Cranford.
 Frederick H. Pierson, 440 N. Broad, Cranford.
 Henry C. Pierson, Roselle.
 H. Morton Pierson, Roselle.
 J. P. Probasco, Plainfield.
 Norman H. Probasco, Plainfield.
 Thomas P. Prout, Summit.
 Stephen T. Quinn, 125 Jefferson ave., Elizabeth.
 John M. Randolph, Rahway.
 J. J. Reason, Carteret.
 John P. Reilly, 215 Elizabeth ave., Elizabeth.
 Charles H. Schlichter 1053 Elizabeth ave., Eliz.
 Frederick W. Sell, Rahway.
 W. Updyke Selover, 149 Mt. Pleas. ave., Newark.
 Russell A. Shirrefs, 1158 E. Jersey, Elizabeth.
 Elihu B. Silvers, Rahway.
 R. R. Sinclair, Westfield.
 Arthur Stern, 218 E. Jersey, Elizabeth.
 J. A. Stites, Springfield.
 R. D. Tomlinson, Plainfield.
 T. H. Tomlinson, Plainfield.
 William F. Turner, 562 Jefferson ave., Elizabeth.
 William B. Van Alstyne, Westfield.
 A. F. Van Horn, Plainfield.
 N. W. Voorhees, 297 N. Broad, Elizabeth.
 Otto Wagner, 1071 Elizabeth ave., Elizabeth.
 Frank Warncke, 310 First ave., Elizabeth.
 F. W. Westcott, Fanwood.
 Rufus B. Whitehead, 310 First ave., Elizabeth.
 Number members, 78.

WARREN COUNTY.

Society organized February 15, 1826. Annual Meeting any Tuesday (at option of Secretary) in May.

Thomas S. Dedrick, *Pres.*, Washington.
 Edward H. Moore, *Vice-Pres.*, Asbury.
 William J. Burd, *Sec'y.*, Belvidere.
 G. W. Cummins, *Treas.*, Belvidere.
 J. H. Griffith, *Rep.*, Phillipsburg.
 John C. Johnson, *Censor*, Blairstown.
 F. J. LaRiew, *Censor*, Washington.
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SUMMARY.

Atlantic	60	Middlesex	39
Bergen	51	Monmouth	41
Burlington	35	Morris	54
Camden	80	Ocean	14
Cape May.....	20	Passaic	86
Cumberland	42	Salem	19
Essex	291	Somerset	20
Gloucester	25	Sussex	16
Hudson	149	Union	78
Hunterdon	25	Warren	26
Mercer	66		
		Total	1237

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To begin with, it's a great advantage to have Fairfield Dairy Certified Milk as a basis of whatever modification is necessary, in specific cases for infant feeding-

Fairfield Dairy was the first Dairy to be under contract with a Medical Commission to insure a product pure, well balanced, and uniform.

The physicians of New Jersey are most of them well aware of our efforts in this direction and of how well we have fully filled the expectation of the medical profession.

For some time the Fairfield Dairy has been conducting at its offices in Montclair, a laboratory equipped in the most modern fashion, to secure most accurate results in adapting certified milk to physicians' prescriptions for infant feeding.

We take pleasure in inviting physicians from all parts of the State to visit our laboratory, question our trained nurses, skilled in this special direction, test our product in every way, and visit the dairy where certified milk is produced.

Our facilities are equal to the necessities of the profession. We work quickly by 'phone and special delivery, and in every way strive to co-operate with physicians in preserving infant life. A few of the special forms of modification which we are constantly called upon to make are given below :

(Milk mixtures raw, pasteurized, sterilized or peptonized; whey, cereal gruels and cereal jellies.)



The Fairfield Dairy

TELEPHONE 140

MONTCLAIR, N. J.

Dairy :

Fairfield, Caldwell Township, N. J.

HOLADIN

The Entire Pancreas Gland Extract

In 3 gr. Capsules

HOLADIN is an extract of the entire pancreas gland, presenting all the constituents both of the digestive and the internal secretion. HOLADIN, whilst possessing great tryptic activity, is of especial potency in respect to the amylolytic and lipolytic enzymes; it is rich in the important cell-constituents, lecithin and nuclein, which peculiarly abound in the pancreas.

HOLADIN is put up in gelatine capsules (automatically filled), each containing approximately three grains. The usual dose is one capsule about three hours after meals, and one at bedtime. In cases of constitutional disease or in serious disorders of digestion attributed to faulty pancreatic functioning the dose may be gradually increased to two or three capsules at a time.

HOLADIN, by the U. S. P. method of assay, exhibits at least four times the starch-converting power of "Pancreatin" U. S. P., 1900, and far exceeds in saccharifying power any diastase of commerce.

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